Celebrating 15 years of promoting mental health and personal growth, one stride at a time!

AUTHORIZATION TO RELEASE INFORMATION

Client Name:	DOB:

I hereby authorize ____

(current therapist)

Located ____

(email address and/or phone number)

To *(check all that apply)*:

❑ Release information to HHP staff clinicians:

- **Sarah Kelava, M.S. LMFT, TRI, ESMHL, TF-EAP**
- **Ruth Ocampo, M.S. LMFT, ESMHL, TF-EAP**
- **Emily Spatz, B.A., Registered Marriage and Family Intern, TRI**

Healing Hooves Psychotherapy Inc.
1157 SE 6th Court
Dania Beach, FL 33004

❑ The above agency and/or representative named to exchange information with each other on an ongoing basis for the duration of the terms of this release.

This release applies to the following information:

❑ Treatment Summary

The purpose of this release is: _**for introduction to the Healing with the Herd Equine Assisted Group clinicians and facilitators. We need to ensure that all participants are actively in therapy and able to process their experiences during the group activity.** ___________________________________

This information is released with the understanding that it is not to be re-released without my written permission or the written permission of my legally-authorized representative, except as required by law. This authorization is limited to the person, agency, school, or insurance company named above and is not to be used for any other purpose than the one specified.
This release will automatically terminate on ______________________.

Client Signature:____Date:_____________
Parent/Guardian: ____ Date:_____________
Therapist Signature:____Date:_____________

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Dania Beach, FL 33004

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