Sheri Russell, MS, MFT
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(408) 710-2001

Release of Information

I authorize Sheri Russell, MFT to share information with

(name) ____

(address) ____

(phone) ____________________________ regarding the therapy sessions of

(child's name) ____,

my (relationship) ______________________.

This release is to remain in effect for one year from date of signature, or until revoked in writing.

Printed Name	Signature
Printed Name	Signature
Therapist	Date