**Participant Information:**

Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age:

Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State:\_\_\_\_ Zip:

Email:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Home Ph:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell Ph:

**Parent/Guardian Information:** Please check if information is same as above [ ]

Parents/Guardians:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State:\_\_\_\_ Zip:

Email \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Home Ph:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell Ph:

Is participant in a foster placement? Yes \_\_\_\_ or No \_\_\_\_ If yes, for how long? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Dependency Case Manager name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Past and/or current traumas:

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Pertinent information for treatment / participation:

Please describe personal and/or family strengths:

Successful Intervention Strategies and/or coping skills used:

Does participant exhibit suicidal, homicidal, or self-harming ideations or behaviors? If yes, explain. ­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

List current medical or mental health diagnosis: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Does participant currently work with a therapist? Yes\_\_\_\_ or No\_\_\_\_ If yes, complete information release.

Please list goals and expectations for treatment: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

This form was completed by (participant/parent/guardian/other):

\* Please attach additional sheets of paper or more information if desired.

**AUTHORIZATION FOR EMERGENCY MEDICAL TREATMENT**

Participant Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth:

Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State:\_\_\_\_ Zip:

Physician’s Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Physician’s Phone Number:

Preferred Medical Facility:

Health Insurance Company: Policy #:

Allergies and Treatment Required:

Current Medications:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Medical Bracelet?

**In the event of an emergency, contact:**

Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relation:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone:

Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relation:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone:

Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relation:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone:

**Consent Plan:** In the event emergency medical aid/treatment is required due to illness or injury during the

process of receiving services, or while being on the property of the agency, I authorize Vinceremos Therapeutic

Riding Center to:

1. Secure and retain medical treatment and transportation if needed.
2. Release client records upon request to the authorized individual or agency involved in the medical emergency treatment.

This authorization includes x-ray, surgery, hospitalization, medication and any treatment procedure deemed

“lifesaving” by the physician. This provision will only be invoked if the person(s) above is unable to be reached.

**Date**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Consent Signature**:

 *Participant (if 18 years or older), Parent or Legal Guardian*

**- or -**

**Non-Consent Plan:** I do not give my consent for emergency medical treatment/aid in the case of illness or

injury during the process of receiving services or while being on the property of the agency.

1. Parent or legal guardian will remain on site at all times during equine assisted activities.
2. In the event emergency treatment/aid is required, I wish the following procedure to take place:

 **Date**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Non-Consent Signature**:

 *Participant (if 18 years or older), Parent or Legal Guardian*

 *(Do not sign here if Consent is signed above)*

**Photo Release:** **I Do** **I Do Not** Consent to and authorize the use and reproduction by Vinceremos

Therapeutic Riding Center of any and all photographs and any other audio/visual materials taken of me for

promotional material, educational activities, exhibitions, or for any other use for the benefit of the Center.

 **Date**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Signature:**

 *Participant (if 18 years or older), Parent or Legal Guardian*

**EQUINE ACTIVITY LIABILITY RELEASE, WAIVER OF**

**RIGHT TO SUE, AND ASSUMPTION OF ALL RISKS**

**READ BEFORE SIGNING**

 This Equine Activity Liability Release, Waiver of Right to Sue and Assumption of All Risks Agreement (the “Agreement”) is hereby given by \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_(Person Signing) on his/her own behalf OR as the parent or guardian of \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (Participant) to VINCEREMOS RIDING CENTER, INC., a Florida not-for-profit corporation, as the equine activity sponsor (the “Sponsor”), and to each officer, director, agent, employee, volunteer, equine professional (as defined in the Act referenced herein), instructor, therapist, aide, heir, personal representative, successor and/or assign of the Sponsor (who also shall be included within the word “Sponsor”) and agrees as follows:

 In consideration of the opportunities provided by the Sponsor to the undersigned, including any minor or legal ward in whose behalf the undersigned signs this Agreement (collectively, the “Participant”), for the enjoyment of equine activities and the use of the Sponsor’s facility and equipment, the Participant hereby agrees as follows:

 1. This Agreement is given in part under the Florida Equine Activities statutes (Chapter 773) as it may now provide or be hereafter amended (the “Act”). All terms defined by the Act shall have the same meaning herein, and the Act is hereby incorporated in this Agreement by reference. This Agreement shall be so construed as to provide to the Sponsor the fullest protection of a release, waiver of claim and recovery, right to sue and assumption of all risks that is afforded by the Act, and by other applicable statutes and general law.

 2. The Participant hereby acknowledges that he/she has full and complete notice and understanding of the Act and of all the dangers and/or conditions which are an integral part of equine activities which may cause, contribute to or result in the death or personal injury of the Participant or damage to the Participant’s property (the “Risks”), including, but not limited to:

 The propensity of equines to behave in ways (such as, but not limited to, buck, stumble, fall, rear, bite, kick, run, and make unpredictable movements, spook, jump obstacles, step on a person’s feet, push or shove a person, saddles or bridles may loosen or break) that may result in injury, harm, or death to persons on or around the equine;

 The unpredictability of an equine’s reaction to sounds, sudden movement, persons, other animals, or unfamiliar objects;

 Hazards, including, but not limited to, surface or subsurface conditions; A collision with another equine, another animal, a

 person, or an object;

 The potential of an equine activity participant to act in a negligent manner that may contribute to injury, death, or loss to the person of the participant or to other persons, including, but not limited to, failing to maintain control over an equine or failing to act within the ability of the participant;

 The inability of anyone whomsoever to predict or foresee an equine’s reaction to excitement, weather conditions, sound, movements, objects, vehicles, persons, animals, reptiles, birds or insects, and the effects of such reactions; The dangers and risks of tack or harness loosening, slipping or breaking for whatever reason.

 The dangers and risks of becoming entangled in tack, harness, or vehicles used in an equine activity; The risks of falling

 from or otherwise becoming unstable on an equine or a vehicle used in an equine activity for any reason whatsoever or for

 no identifiable reason; Any negligent act or omission by the Sponsor which causes or results in the death or personal injury

 of the Participant or damage to the Participant’s property.

 3. The Participant hereby expressly assumes all risks and dangers of injury, loss, damage or death which are in any way resulting from the inherent risks of equine activities and/or associated with the Risks enumerated in paragraph 2 above.

Initial:\_\_\_\_\_\_\_\_\_\_\_\_

Date:\_\_\_\_\_\_\_\_\_\_\_\_

 please initial

 4. The Participant hereby releases and waives all rights which he/she may have or hereafter have against the Sponsor for injury, loss, damage or death which is in any way resulting from the inherent dangers of equine activities and/or associated with the Risks enumerated in Paragraph 2 above, and the right to sue or to bring any action against the Sponsor in connection therewith. The Participant agrees to completely indemnify and hold the Sponsor harmless from and against any and all claims, demands, causes of action, suits, actions, losses, liabilities, costs and/or expenses, including medical costs and attorney's fees, which are occasioned by, or otherwise attributable to, matters for which the Participant has hereby assumed the risk and is responsible in accordance with this Agreement.

 5. The Participant agrees to comply with all rules and regulations posted or otherwise communicated by the Sponsor. The Participant agrees that the Sponsor has made reasonable and prudent efforts to determine the Participant's ability to engage in the Equine Activity offered by the Sponsor and the Participant has disclosed all known physical and psychological conditions to Sponsor to assist Sponsor in evaluating the Participant for participation in the Equine Activity offered by the Sponsor.

 6. The Participant agrees that mounting, riding, walking, dismounting, grooming, training, handling, feeding, and otherwise being in the physical proximity of horses is a dangerous activity which produces a foreseeable risk of mortal or serious personal injury and/or property loss to the Participant in such activity as well as to the person or property of others.

 7. This Agreement shall remain valid and in full force and effect from and after the date opposite the signature of the Participant until expressly revoked by the Participant in a written notice personally delivered to the Sponsor.

 8. This Agreement shall be construed under Florida law in such manner as will render it, and each provision of it, fully enforceable; provided, however, that if any provision of this Agreement shall be unenforceable, such provision (or so much thereof as is unenforceable) shall be deleted and the remainder of this Agreement shall continue in full force and effect. Venue for purposes of any litigation or arbitration concerning this Agreement shall be in Palm Beach County, Florida.

 9. If this Agreement is executed by the undersigned for and on behalf of a minor Participant as named below, the undersigned hereby warrants and represents that he/she is in fact the legal parent or guardian of such minor, with full rights of custody and control; that this Agreement is given on behalf of and is intended to be binding upon said minor Participant, his/her heirs, personal representatives, successors and assigns; and the undersigned further agrees that this Agreement shall also be as fully binding on the undersigned as if it were entered into solely on his/her own behalf.

 10. This Agreement shall be binding upon the heirs, personal representatives, successors and assigns of the Participant and the undersigned.

**WARNING**

**Under Florida Law, an equine activity sponsor or equine professional is not liable for any injury to, or the death of, a participant in equine activities resulting from the inherent risks of equine activities.**

I HAVE FULLY READ AND FULLY UNDERSTAND THE FOREGOING EQUINE LIABILITY RELEASE, WAIVER OF RIGHT TO SUE AND ASSUMPTION OF ALL RISKS. I HAVE CONSULTED AND RELIED UPON MY OWN ADVISORS ON ALL QUESTIONS IN CONNECTION THEREWITH AND FULLY UNDERSTAND ITS TERMS, UNDERSTAND THAT I HAVE GIVEN UP SUBSTANTIAL RIGHTS BY SIGNING IT, AND SIGN IT FREELY AND VOLUNTARILY WITHOUT ANY INDUCEMENT. I HAVE NOT RELIED UPON THE SPONSOR FOR ANY ADVICE OR EXPLANATION IN CONNECTION THEREWITH.

**Print Name**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date**:

**Signature**:

 *Participant (if 18 years or older), Parent or Legal Guardian*

FOR MINORS UNDER 18 YEARS OF AGE:

Print Name of Minor: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address:

Telephone Numbers: Cell (\_\_\_) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Home (\_\_\_\_) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work (\_\_\_\_) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Equine-Assisted Psychotherapy (EAP)**

**Informed Consent**

**Introduction** This document is intended to provide information to you regarding services being rendered. Please read the entire document prior to consenting for services. It is your right as a client to have a complete explanation for any questions you might currently have, or in the future.

**What is EAP?** Vinceremos offers a treatment modality called **Equine-Assisted Psychotherapy** which is an experiential form of psychotherapy where horses are involved in the sessions. EAP activities are done on the ground, no riding is involved. “Experiential” means that you will be involved in hands-on experiences with the horses designed to reflect things going on in your life. The process is not always about interacting with the treatment team, although that will happen at times. It is about providing you the opportunity to experience, explore, problem-solve, discover, be creative, gain insight and experience practical applications of what you are learning in the moment. The process is about “doing” along with the “talking.”

**Fees** Equine Assisted Psychotherapy and Learning sessions are billed at a rate of $150/hour for individuals. Group sessions are $400 (minimum of 3 people for 1.5 hours). Beyond that, the rate varies according to length of session and number of participants. You are responsible for paying at the time of your session (start of session) unless prior arrangements have been made. Typical groups are 3-8 participants and occur the same time frame, weekly.

**Counseling** is a confidential process designed to help you address your concerns, come to a greater understanding of yourself, and learn effective personal and interpersonal coping strategies to improve multiple areas of functioning. Counseling involves sharing sensitive, personal, and private information that may at times be distressing. During the course of counseling, there may be periods of increased anxiety or confusion. The outcome of counseling is often positive; however, the level of satisfaction for any individual is not predictable.

**Treatment Planning** The first 2 sessions will involve assessing your needs and working with you to create a treatment plan to outline your therapy goals and objectives and address any questions regarding diagnosis, goals and estimated length of treatment. We will periodically review this plan with you to discuss progress or changes in the therapy goals. If you have questions about our procedures, please discuss them with us whenever they arise.

**Termination of Therapy** The length of your treatment and the timing of the eventual termination of your treatment depend on the specifics of your treatment plan and the progress achieved. It is a good idea to plan for your termination, in collaboration with us. Together we will discuss a plan for termination with you as you approach the completion of your treatment plan goals. You may discontinue therapy services at any time. If you or your counselor determine that you are not benefitting from treatment, either of you may elect to initiate a discussion of your treatment alternatives. Treatment alternatives may include, among other possibilities, referral, changing your treatment plan, or terminating your therapy. It is best to discuss this in a planned termination session if at all possible.

**Appointments** will ordinarily be 50 minutes in duration for individuals and 90 minutes for groups, once per week at an agreed upon time, although some sessions may be more or less frequent as needed. If you need to cancel or reschedule a session, we ask that you provide us with 24 hours' notice. If you miss a session without canceling, or cancel with less than 24 hours' notice, our policy is to collect 50% of the session fee (unless we both agree that you were unable to attend due to circumstances beyond your control). If it is possible, we will try to find another time to reschedule the appointment. In addition, you are responsible for coming to your session on time; if you are late, your appointment will still need to end on time. Participants who miss 2 consecutive sessions without notifying the office will be considered withdrawn.

In addition to appointments, it is our practice to charge this amount on a prorated basis (we will break down the hourly cost) for other professional services that you may require such as report writing, telephone conversations that last longer than 15 minutes, attendance at meetings or consultations which you have requested, or the time required to perform any other service which you may request of us. If you anticipate becoming involved in a court case, we recommend that you discuss this with us fully before you waive your right to confidentiality. If your case requires our participation, you will be expected to pay for the professional time required even if another party compels us to testify. Rate of $350/hour for court participation and preparation including travel time. Minimum 8 hours. This fee is standard; whether participant is on scholarship or sliding scale, they are required to pay fee in full.

**Records and Record Keeping** Individual and family sessions will be noted as part of record keeping. These notes constitute our clinical and business records, which by law, we are required to maintain for at least 10 years. Clinical records are the sole property of Vinceremos Therapeutic Riding Center. A request for records must be made in writing. We reserve the right under Florida law, to provide you with a treatment summary in lieu of actual records. We also reserve the right to refuse to produce a copy of the record under certain circumstances, but may, as requested, provide a copy of the record to another health care provider. A fee of $1.00 per page will be charged to the requesting party.

**CONFIDENTIALITY**

**All interactions with counseling services, including scheduling of or attendance at appointments, content of your sessions, progress in counseling, and your records are all confidential. No record of counseling is contained in any academic, educational, or job placement file. You may request in writing that the counseling staff release specific information about your counseling to persons you designate with an “Authorization for Release or Exchange of Information Form”.**

**EXCEPTIONS TO CONFIDENTIALITY**:

* The counseling staff work as a team. Your therapist may consult with other counseling staff to provide the best care possible. These consultations are for professional and training purposes.
* If there is evidence of clear and imminent danger of harm to self/or others, a therapist is legally required to report this information to the appropriate authorities responsible for ensuring safety.
* Florida State Law require that staff of counseling services who learn of, or strongly suspect, physical or sexual abuse or neglect of any person under 18 years of age must report this information to county child protection services.
* A court order, issued by a judge, may require the counseling services staff to release information contained in records and/or require a therapist to testify in court hearing.

**I have read and discussed the above information with my therapist. I understand the risks and benefits of counseling, the nature and limits of confidentiality, and what is expected of me as a client of the counseling services. Your signature below indicates that you have read and understand this Agreement and agree to their terms.**

X\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­­­­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of client / Parent /Guardian or Authorized Representative Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Printed name of Authorized Representative Relationship / Capacity to patient

**Authorization for the Release or Exchange of Information**

Client Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If client is under the age of 18 years old, guardian must fill out

Guardian Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Ph #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**The purpose of disclosure is:**

[ ]  Continuation of Care and/or facilitation of services

[ ]  Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Method of contact allowed:** [ ] Phone [ ] Fax [ ] Email [ ] In person

**This information may be disclosed and used by the following individual(s) or organization(s):**

Release to: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City, State, Zip: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­­­\_

Fax: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Expiration: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Release to: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City, State, Zip: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­­­\_

Fax: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Expiration: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Release to: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City, State, Zip: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­­­\_

Fax: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Expiration: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I understand I may revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the health information management department. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire on the following date, event, or condition: **Discharged.** If I fail to specify an expiration date, event, or condition, this authorization will expire 1 year from the date signed. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that I may inspect or obtain a copy of the information to be used or disclosed, as provided in CFR 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized redisclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact the authorized individual or organization making disclosure. I have read the above foregoing Authorization for Release of Information and do so hereby acknowledge that I am familiar with and fully understand the terms and conditions of this authorization.

By signing below, I hereby authorize this release/ exchange of information,

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Client Signature (Guardian) Date