Equine Magic Therapeutic Services

Participant's Consent for Release of Information

Name of insurance company: ____
Policy number:________________________ **Group number:** ___________________
Subscriber number: ________________________________
Address and phone number of insurance company: __________________________________
____
Name of insured: ___________________________ **Date of Birth:** ______________
Name of Patient: ___________________________ **Date of Birth:** ______________
Relationship to insured: ______________________ **Diagnosis:** _____________________

I hereby authorize:____
(*person or facility)*

To release information from the records of:______________________ **DOB** _______

The information is to be released to:____
(center or therapist's name)

For the purpose of developing a hippotherapy program for the above named participant. The information to be released is indicated below.

☐ **Medical History**
☐ **Physical Therapy evaluation, assessment and program plan**
☐ **Occupational Therapy evaluation, assessment and program plan**
☐ **Speech Therapy evaluation, assessment and program plan**
☐ **Mental Health diagnosis and treatment plan**
☐ **Individual Habilitation Plan (I.E.P)**
☐ **Classroom Individual Education Plan (I.E.P.)**
☐ **Psychosocial evaluation, assessment and program plan**
☐ **Cognitive-Behavioral Management plan**
☐ **Other:**____

This release is valid for one year and can be revoked, in writing, at my request

Signature:____ **Date:**_____________

Print name:____

Realationship to participant:_________________________________

Please send materials to:____
____