Rocky Mountain Riding therapy
P.O. Box 909 Louisville, CO 80027 303-494-1299

Participant's Consent for Release of Information

I hereby authorize: _____
(person or facility)
to release information from the records of:_____
DOB: _____. *(participant's name)*

The information is to be released to: ROCKY MOUNTAIN RIDING THERAPY for the purpose of developing an equine activity 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.H.P.)
- ☐ Classroom Individual Education Plan (I.E.P.)
- ☐ Psychosocial evaluation, assessment and program plan
- ☐ Cognitive-Behavioral Management Plan
- ☐ Other:

Please send information to Rocky Mountain Riding Therapy at the address listed above.

_____

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

Signature: _____ Date: _____

Print Name: _____

Relation to Participant: _____