Healing Hooves Information Release Form

Complete this form only if you want us to give information or records about you, a minor, or a legally incompetent adult, to an individual or group (for example, a doctor or an insurance company). If you are the natural or adoptive parent or legal guardian, acting on behalf of a minor child, you may complete this form to release only the minor's non-medical records.

I understand that Healing Hooves Therapeutic Horsemanship has an obligation to keep personal information, identifying information, and records confidential. I also understand that I can choose to allow Healing Hooves to release some personal information to certain individuals or agencies.

I, _____, authorize Healing Hooves to share the following specific information with:

Full
Name:_____

Who I want to have my information:

Name:

Specific Office at Agency:

Phone Number:

The information may be shared: in person by phone by fax by mail by e-mail

I understand that electronic mail (e-mail) is not confidential and can be intercepted and read by other people.

What information will be shared:

_____

_____

_____

(List as specifically as possible, for example: name, dates of service, any documents).

Why I want this info shared:
(purpose)_____

_____

(List as specifically as possible, for example: to receive benefits).

Please Note: there is a risk that a limited release of information can potentially open up access by others to all of your confidential information held by Healing Hooves.

I understand:

_____That I do not have to sign a release form. Signing a release form is completely voluntary. That this release is limited to what I write above. If I would like Healing Hooves to release information in the future, I will need to sign another written, time-limited release.

_____That releasing information could give another agency or person information about my location and would confirm that I have been receiving services from Healing Hooves.

_____That Healing Hooves and I may not be able to control what happens to the information once it has been released to the above person or agency, and that the agency or person getting my information may be required by law or practice to share it with others.

This release expires on _____, _____ (Date Time)

Healing Hooves Participant:

Name:_____
_____

I understand that this release is valid when I sign it and that I may withdraw my consent to this release at any time either orally or in writing.

Date:_____

Signed:_____
_____

Time:_____

Witness:_____

Reaffirmation and Extension (if additional time is necessary to meet the purpose of this release)