# Equinox Horse Foundation

## Release of Medical Information

I HEREBY AUTHORIZE THE FOLLOWING PERSONS OR FACILITIES INVOLVED WITH THE CARE OF:

_____

*(RIDER'S NAME)*

TO RELEASE INFORMATION TO EQUINOX HORSE FOUNDATION FOR THE PURPOSE OF DEVELOPING A THERAPEUTIC RIDING PROGRAM FOR THE ABOVE NAMED RIDER. THE INFORMATION TO BE RELEASED IS MARKED BELOW:

☐ PHYSICAL THERAPY EVALUATION, ASSESSMENT, AND PROGRAM PLAN
Name:_____ Phone: _____ Email:_____

☐ OCCUPATIONAL THERAPY EVALUATION, ASSESSMENT, AND PROGRAM PLAN
Name:_____ Phone: _____ Email:_____

☐ SPEECH THERAPY EVALUATION A, ASSESSMENT AND PROGRAM PLAN
Name:_____ Phone: _____ Email:_____

☐ PSYCHOLOGICAL THERAPY EVALUATION, ASSESSMENT, AND PROGRAM PLAN
Name:_____ Phone: _____ Email:_____

☐ CLASSROOM INDIVIDUAL EDUCATION PLAN (I.E.P)
Name:_____ Phone: _____ Email:_____

☐ MEDICAL HISTORY
Name:_____ Phone: _____ Email:_____

☐ OTHER
Name:_____ Phone: _____ Email:_____

Only specified Equinox Horse Foundation personnel will have access to any protected health information of the client at any given time and no PHI is released from Equinox Horse Foundation unless permission is given in writing by the client or legal guardian of the client. By signing below you are indicating that you have been informed of this policy.

Date: _____ Signature: _____
Client, Parent, or Legal Guardian