



Reining Hope Adaptive Equine Assisted Activities & Therapies LLC

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"Wish It, Dream It, Do It!"

CONSENT FOR RELEASE OF INFORMATION

I hereby authorize _____
Person(s) or Place(s) releasing information

to release information from the records of _____,
Participant's name

DOB: _____.

The information is to be released to Reining Hope AEAAT LLC for the purpose of developing an equine assisted activity program for the above-named participant.

The information to be released is marked below:

_____ Medical History

_____ Physical Therapy evaluation, assessment and program plan

_____ Occupational Therapy evaluation, assessment and program plan

_____ Speech Therapy evaluation, assessment and program plan

_____ Psychosocial evaluation, assessment, program plan and discharge summary

_____ Classroom Individual Education Plan (I.E.P.)

_____ Cognitive-Behavioral Management Plan

_____ Other: _____

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

Please send the indicated material to Reining Hope AEAAT LLC at the address above. Thank you!