DIVINE INTERACTIONS EQUINE FACILITATED WELLNESS, LLC

Mailing/Billing:
P.O. Box 165
Avonmore, PA 15618

Practice Location:
276 PA-156
Avonmore, PA 15618

Phone: 724.567.8988

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Email: info@divineinteractionsefw.com

I hereby authorize Divine Interactions Equine Facilitated Wellness, LLC to release information from the records of

_____ D.O.B. _____.

☐ *By checking this box I authorize information to be exchanged freely by both parties identified in this release*

The information to be released is:

Psychiatric/Counseling Evaluation _X_
Medical History _X_
Social History _X_
Discharge Summary _X_
Course of Treatment _X_
Lab Reports _X_
Medications _X_
Status in Treatment_X_
Verbal Communication _X_
_X_Other (specify): _____demographic/contact information_____

Developmental History _X_
Academic/School Records _X_
Attendance Records/Appointments _X_
Teachers/Counselors Comments _X_
Complete Behavioral Checklist _X_
Recommendations _X_
Psych/Achievement Tests _X_
Treatment Summary _X_

Records are requested for the purpose of: __X_ Coordination/Continuity of Care

__X_ Other: ___Scheduling, Payment, Etc._____

Dates of Service Requested: _____all dates of service from both providers_____

(Please note: HIV, Mental Health, and Drug and Alcohol information contained in this consent will be released unless indicated.)
Do not release:
Mental Health _____ HIV _____ Drug and Alcohol _____

I understand that this authorization is effective for a period of one year from the date of signature, unless otherwise specified below. No time frame may exceed one year from the date of signature. I understand that I have the right to revoke this authorization at any time by sending a written request to the person I authorized above to release the information. If applicable, specify other expiration date below.

Client Signature: _____ Date: _____

Please forward information to and/or from:

Name of Provider/Facility:_____Boeser Equine, LLC (Samantha Boeser)_____

Address: _____292 Fox Road Apollo, PA 15613_____

Phone/Fax Number: _____412.327.5340_____

I have been informed that in order to protect the limited confidentiality of records, my agreement to obtain or release is necessary, and this permission is limited for the purposes and to the person listed above and will be effective during the date listed below. I also understand that this consent is revocable except to the extent which records have been sent.

This consent shall be in effect from: _____ until _____

Client Signature: _____ Date: _____

Legal Guardian Signature: _____ Date: _____

Authorized Representative Signature: _____ Date: _____

Oral Consent (NOT VALID FOR D&A) Dated: _____

Authorized Representative Signature: _____

Authorized Witness Signature: _____