BLUE SKY RANCH
HORSES • HOPE • HEALING

CLIENT AUTHORIZATION TO RELEASE INFORMATION FORM

BSR THERAPY SERVICES

I, (print name) _____, hereby authorize BSR Therapy Services

to release the information designated below from my (my child's - print client's name) _____

_____ clinical records.

This authorization is valid only to:

Individual: _____

Agency: _____

Address: _____

For the purpose of: _____

Designate which of the following is to be release:

Yes	No	
_____	_____	Summary of clinical treatment including diagnosis and progress toward Goals
_____	_____	Recommendations and/or consultation
_____	_____	Other (specify) _____

I understand that I may revoke this consent at anytime and that upon fulfillment of the above stated purpose(s), this consent will automatically expire without my express revocation.

Client or Guardian Signature: _____

Relation to Client _____ Date: _____