SPECIALIZING IN
HORSE ASSISTED
THERAPIES

Consent to Release or Request Information for Physician's Order

Mended Hearts Stable, Inc.
1431 Lourdes Road, Metamora, Illinois 61548

Occupational Therapy Services

Client Information			
Name			
D.O.B.		Parent/Guardian	
Address			
Phone		Email	

In order to allow client to receive a therapy evaluation, continue or initiate services, and to facilitate communications, your written consent to obtain and release records is required. Please fill in the following information.

Indicate any additional physicians and/or agencies (clinics) to be included in client's treatmen planning.

_____

I give consent to **Mended Hearts Stable, Inc.** to release written therapy reports and verbal information, and to obtain medical referrals for therapy, medical records, and reports, and verbal information regarding the medical/therapy needs, to/from:

Primary Physician: _____

Address: _____

Phone: _____ Fax: _____

This release is effective for the following dates: _____

Please return to Mended Hearts Fax #: 309-383-3399

Parent/Guardian/Client Signature: _____ Date: _____