



**DENIM & DIRT**  
EQUINE ASSISTED GROWTH AND LEARNING

## Release of Information and Emergency Contact

Please complete this form which includes an Emergency Contact as well as any medical/psychological practitioners which could provide information that could be helpful to me in facilitating your EAGL experience.

**Emergency Contact** \_\_\_\_\_

Relationship \_\_\_\_\_ Telephone Number \_\_\_\_\_

### Authorization for Release of Information

I, \_\_\_\_\_, date of birth \_\_\_\_\_, authorize Dr. B. Jane Wick or DnD EAGL representative to obtain information from or release information to:

**Primary Care Physician** \_\_\_\_\_

**Current Psychiatrist** \_\_\_\_\_

This information includes any medical or psychological records pertinent for the purpose of evaluation and/or treatment planning. This authorization is given of my own free will. I understand that I can revoke this authorization in writing at any time.

Patient \_\_\_\_\_ Date \_\_\_\_\_

Witness \_\_\_\_\_ Date \_\_\_\_\_