

**Reins From Above Therapeutic Riding Center, Inc.**

86 Polenta Road

Smithfield, NC 27577

Phone: 919-938-1556

Website: [www.reinsfromabove.org](http://www.reinsfromabove.org)

**Participant's Consent for Release of Information  
(Only Required for Participants with Disabilities)**

Date: \_\_\_\_\_

Client/Participant Name: \_\_\_\_\_

Client/Participant Address: \_\_\_\_\_

Client Social Security Number: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Please List All Current Primary Care Physicians, Therapists (occupational, physical, speech, or mental health professionals), Special Education Teachers, or other professionals who may have information relevant to the safety, health, training, or goals for this participant in a therapeutic riding program. Use the back of this sheet if necessary for additional information;

Name of Professional	Type of Professional	Address	Phone
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

I hereby authorize any or all of the above-named professionals to release: medical histories; Physical Therapy, Occupational Therapy and Speech Therapy evaluations, assessments, and program plans; Classroom Individual Education Plans (I.E.P); and psychological/psychiatric histories, diagnoses, and evaluations to: **Reins From Above Therapeutic Riding Center, Inc.** for the purpose of developing a Therapeutic Riding Program for the client named above.

**(Parents/legal guardians must sign for children under 18 or wards of the court. Both parents/guardians must sign below if there is joint or shared custody.)**

Date: \_\_\_\_\_ Signature: \_\_\_\_\_ Print Name: \_\_\_\_\_  
(Client, Parent, or Guardian)

Date: \_\_\_\_\_ Signature: \_\_\_\_\_ Print Name: \_\_\_\_\_  
(Client, Parent, or Guardian)