

Hoofbeats Therapeutic Riding Center, Inc.

At the Virginia Horse Center

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Professional Association of Therapeutic Horsemanship International

A Premier Accredited Member Operating Center

Request to Release Protected Health Information to Provider

I, (Print rider's full name) _____, do hereby authorize and request that Hoofbeats Therapeutic Riding Center release riding/therapy records to the following provider

(Print provider's name) _____, for the purpose of medical care/therapy.

Patient Information

Address: _____ Date of Birth: _____
 _____ Social Security No #: _____
 _____ Phone #: (_____) _____

Provider Information

Address: _____ Phone #: (_____) _____
 _____ Fax #: (_____) _____
 _____ Send results by: ___ Fax ___ Mail

I, the Patient or Patient's Representative, understand that:

- My records are confidential and may be disclosed only as authorized in this consent or required by law.
- I have the right to revoke this authorization at any time. I understand if I revoke this authorization I must do so in writing and present any written revocation to Hoofbeats Therapeutic Riding Program. The revocation will not apply to records already released prior to Hoofbeats receiving the revocation.
- I understand that my record may include information relating to medical conditions. It may also include information about behavioral or mental health services, and treatment for alcohol or drug abuse.
- I understand any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact Hoofbeats Therapeutic Riding Center.
- This authorization will automatically expire one year after the date below.

Signature of patient or patient's representative: _____ Date: _____

If requested by Patient's Representative, print Representative's Name: _____

Representative's relationship to patient: _____

Identity confirmed by: ___ Photo ID (ex. Valid driver's license) ___ Copy of Power of Attorney Attached (If applicable)

NOTE: This information has been disclosed to you from records protected by Federal Confidentiality rules (42 CFR Part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. Hoofbeats will not release the requested records until a completed form is received. The rider and/or the rider's representative is responsible for providing correct contact information and Hoofbeats will be held harmless if such contact information is incorrect.