HorsePlay: Equine Assisted Enrichment & Psychotherapy

GETTING HERD: A TEEN GROUP WORKSHOP WITH HORSES

Getting Herd is funded wholly by a THRIVE Grant from the Maya Gold Foundation. Maya Gold, a 15-year-old New Paltz HS student, took her own life in October of 2015. The Maya Gold Foundation was created in her honor to promote wellness, empathy, respect, creativity, and joy amongst youth and adults in the New Paltz area. www.MayaGoldFoundation.org

Participant Name _____ DOB / /

Name of Participant's Guardian _____

Guardian Address _____ ZIP

Participant Address if Other _____ ZIP

Participant Phone Number _____ Cell/ Home/Work (Circle One)

Guardian Phone Number _____ Cell/ Home/ Work (Circle One)

Okay to identify ourselves in voicemail message? (Circle One) Yes No

Guardian's Email _____

Participant's School _____ Grade Level ____ or Home School (circle)

School Counselor*_____Phone Number _____

School Counselor Email_____

Current Therapist (if applicable)*_____

Phone Number _____

Please fill out attached release form in order for us to be able to communicate with school counselor and/or therapist prior to attending the group.

EMERGENCY CONTACT:

Name_____

Relationship _____

Phone Number _____

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Request/Authorization to Release Confidential Records and Information

Client's name: _____Date of Birth: _____

Parent or Guardian name: _____

Client Address: _____ Client Phone #: _____

I hereby authorize **Hudson Valley HorsePlay/ Cori Nichols, ES and Rosemary Rouhana, LMHC, NCC**

To release/ receive information to/from:

Person or Facility:_____Phone: _____

Address: _____

Specific Information to be released/received:

❑ Further mental health evaluation ❑ Treatment Plans/Reviews ❑ Complete Psychosocial History

❑ Attendance in counseling ❑ Diagnosis ❑ Prognosis

❑ Other (Specify): _____
(Academic Info, Psych Evaluation, Intake Forms, Medication Information, Physical Health Info, Discharge Summary)

Permission to release/receive information via: ❑ Telephone ❑ Paper Record
The reason I am authorizing release is:

_____
(Initial/Ongoing Care or Treatment, Assessment/Evaluation, Treatment Planning, etc)

This Authorization will expire on termination of treatment/ discharge or I may revoke this authorization at any time.

Authorization and Signature: I have had explained to me and understand this request/authorization to release records and information, including the nature of the record and their contents. I authorize the release of my confidential protected health information, as described in my directions above. I understand that this authorization is voluntary, that the information to be disclosed is protected by law, and the use/disclosure is to be made to conform to my directions. I understand that I may take back this consent at any time, except to the extent that action based on this consent has already been taken.

_____ _____ _____
Signature of client Printed name Date

_____ _____ _____ _____
Signature of parent/guardian/representative Printed name Relationship

_____ _____ _____
Signature of Therapist Printed name Date

HorsePlay at Nichols Field / 98 Sherman Road / Kerhonskon, NY / 12446
(845) 616 – 3608 / Cori.Nichols@aol.com / www.HudsonValleyHorsePlay.com

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PATIENT RIGHTS AND HIPAA AUTHORIZATIONS

The following specifies your rights about this authorization under the Health Insurance Portability and Accountability Act of 1996, as amended from time to time ("HIPAA").

1. Tell your mental health professional if you don't understand this authorization, and they will explain it to you.
2. You have the right to revoke or cancel this authorization at any time, except: (a) to the extent information has already been shared based on this authorization; or (b) this authorization was obtained as a condition of obtaining insurance coverage. To revoke or cancel this authorization, you must submit your request in writing to your mental health professional and your insurance company, if applicable.
3. You may refuse to sign this authorization. Your refusal to sign will not affect your ability to obtain treatment, make payment, or affect your eligibility for benefits. If you refuse to sign this authorization, and you are in a research-related treatment program, or have authorized your provider to disclose information about you to a third party, your provider has the right to decide not to treat you or accept you as a client in their practice.
4. Once the information about you leaves this office according to the terms of this authorization, this office has no control over how it will be used by the recipient. You need to be aware that at that point your information may no longer be protected by HIPAA.