OPEN SKY

Consent for Release of Psychological & Medical Information

Please include family, programs, educational consultant, home therapist(s), psychologist, psychiatrist, hospital social worker, school counselor, primary care physician and other involved professionals, etc., as applicable

Student Name:	**Date of Birth:**
Parent/Guardian(s):	**Enrollment Date:**

Please complete as many fields as possible.

Name (individual or organization)**:**	**Phone:**
Relationship to Student:	**Email:**

Name (individual or organization)**:**	**Phone:**
Relationship to Student:	**Email:**

Name (individual or organization)**:**	**Phone:**
Relationship to Student:	**Email:**

Name (individual or organization)**:**	**Phone:**
Relationship to Student:	**Email:**

Name (individual or organization)**:**	**Phone:**
Relationship to Student:	**Email:**

This authorization for use or disclosure of medical information is being requested to comply with the terms of the Confidentiality of Medical Information Act of 1981, Civil Code Sections 56 et seq. The purpose of this release is to allow the Open Sky treatment team to communicate with the above named professionals regarding your care.

I authorize the above named professionals and programs to release and receive information concerning me and my treatment to and from Open Sky Wilderness Therapy ("Open Sky"). Information should include as much of the following as would be helpful in providing additional assessment and continuation of care: psychological evaluations, academic evaluations, treatment history, treatment plans/goals, review of therapy or progress case notes, discharge summaries, research studies, physical examinations, labs, blood work and health histories. Such information shall be used by Open Sky to permit assessment of Student to provide appropriate continued care.

I further authorize the release of this information to be received via email, internet technology, fax, voicemail or US mail. While every effort will be made for confidentiality, Open Sky accepts no responsibility in the mis-transmission that could result or information becoming available to someone other than the intended receiver.

This authorization will remain in effect for a period of one (1) year from the date of signature, set forth below.

I understand that our confidential records are protected under the federal confidentiality regulations and cannot be disclosed without our written consent unless otherwise provided for in the regulations.

I certify that this authorization has been made freely, voluntarily and without coercion. I understand that I may revoke this authorization at any time except to the extent that the action has already been taken.

_____	_____	_____
Student Name	Student Signature	Date