

Outdoor Achievement Group, L.L.C.

Youth Behavioral Health Services
Authorization for Release of Information

I. Client's Personal Information

Child's Name: _____ Date of Birth: ____ / ____ / ____

II. Authorization for Release of Information

I, _____, _____, hereby authorize
(Parent or Legal Guardian Name) *(Social Security Number)*

the disclosure and sharing of medical, mental health, and educational information as outlined in Section III related to my minor child (Section I) between the Outdoor Achievement Group, L.L.C., 10600 South Penn, Oklahoma City, Oklahoma 73170, and _____

(Name and Address of Treatment Facility, Institution, or Individual)

III. Information to be Disclosed, Method of Disclosure, and Purpose of Disclosure

Please include the following information related to the medical and or mental health treatment of my minor child (Section I).

Information to be Disclosed

- Records Pertaining to Wilderness-Based Therapy
- Complete Medical Record
- Complete Mental Health Record
- Academic Records
- Disciplinary Records

Method of Disclosure

- Copies Via Mail (including electronic mail) or Fax
- Verbally

Purpose of Disclosure

- To Permit Coordination and Collaboration of Care

*The following items should be excluded from disclosure:

IV. Parent or Legal Guardian Authorization

At any time, I may revoke this consent orally or in writing. I understand that the revocation will not be effective retroactively for information exchanges that have already occurred. Unless otherwise noted, this consent expires one (1) year from the date of my signature below.

_____ Date: ____ / ____ / ____
(Signature of Parent or Legal Guardian)

_____ Date: ____ / ____ / ____
(Signature of Witness)