# Life Skills Recovery Ranch

## Release of Information

Intern Name _____

Address_____

City_____ State_____ Zip_____

Phone_____ Date of Birth_____

I, _____, understand that Life Skills Recovery Ranch must have specific information relating to my recovery and their ability to provide services. By signing this form, I am allowing the Life Skills Ranch to exchange pertinent information with outside providers to more effectively provide or coordinate services on my behalf. I understand that information may be shared in written form, during meetings, by phone and through email or computerized data.

I give my consent to Life Skills Recovery Ranch to obtain and exchange information in the areas of medical, psychological and/or psychiatric, academic and vocational through correspondence with the following individuals:

(Please check all that apply)

- ☐ Medical, psychological and/or psychiatric personnel
- ☐ Parent(s) or legal guardian(s)
- ☐ Faculty and staff of past, present and future organizations
- ☐ Employers – past, current and future

I can withdraw this consent at any time by informing Life Skills Recovery Ranch. I understand I am entitled to receive a copy of this consent. I have read this consent carefully and have had all my questions answered. This consent expires twelve (12) months from the date it is signed and will be reviewed every six (6) months.

_____ _____

Intern Signature Date

_____ _____

Witness Signature Date