Authorization for Mental Health Release of Information

Student's name:___________________________________D.O.B.:__________________

Healthcare Professional's Name____

Role with student:____

Email: ________________________________ Phone Number: ______________________

I hereby authorize __________________________ to communicate with Rooted Life Adventures (RLA) and share the following information in writing/verbally:

- Medical history and evaluation(s)
- Mental health evaluations
- Developmental and/or social history
- Treatment plan and goals
- Progress notes and treatment or closing summary

For the purpose of the mutual care and support of the student:

Pre-Program

- Therapist and RLA's Wellness Director will discuss student fit for program
- If Goodness of Fit is determined, the above information will be used for the planning of appropriate RLA program experience, care, and wellness goals
- Therapist will help student prepare for upcoming program experience

During Program

- Wellness Director will conduct psychoeducational curriculum and experiential learning
- Therapist will meet with the student virtually each week
- Therapist will receive weekly program updates from Wellness Director regarding student progress, goals, challenges, and successes on program
- Wellness Director may call for 15 min consult if necessary
- Therapist will be notified in the event of any incidents or necessary behavior adjustments

Post Program

- Therapist will assist student in reintegrating back home with seamless continuity of care

I understand that this authorization may be revoked in writing at any time, except to the extent that action has already been taken to comply with this request. This authorization will automatically expire in twelve (12) months unless otherwise revoked or indicated to expire on _________________ (date not to exceed twelve months).

Student Signature:_________________________________Date:____________________

Parent Signature: _____________________________________Date:_______________