



Fulcrum All -Terrain Therapeutic Services, LLC.

Mobile & Online Support

madcityfulcrum.com

608-618-6552

Release Of Information

Client Name: _____

Date of Birth: _____

Address: _____

Phone Number: _____

I authorize communication between Fulcrum All-Terrain Therapeutic Services, LLC and the listed contact for a **period of 1 year from date of signature.**

Contact information for recipient of consent to release (Provider, Agency, or Individual):

Name: _____

Address: _____

Phone Number: _____

Please provide a description of the kind of information you are authorizing access for (Example: Progress Notes, Support Services, Medical, Mental Health, Treatment Plans, IEP's, Academic Records, Historical and/or Social History, etc.).

Information shared limited to: _____

Or

Any information related to the above listed client.

Client signature (Legal guardian, if under 18): _____

Relationship to Client: _____

Date signed: _____

****This consent for release expires one year from the date signed.***