Mental Health Professional Authorization & Medical History
Authorization for Release of Confidential Information Form

Applicant: Please read and complete Page 1 before sending pg 1-6 to your Mental Health Provider.

Mental Health Provider: Page 1 is provided should you chose to keep a copy for your records. Page 2-6 are for you to complete. Pages 1-6 should then be mailed directly from the provider to New Horizons Service Dogs.

Applicant Information

Applicant name (last, first, m.i.)		Birth date (mm/dd/yyyy)	Daytime telephone number
Applicant street address	City	State	Zip code

NHSDI Program Information

Program Name	Telephone number	Fax number
New Horizons Service Dogs	386-456-0408	386-456-0409

NHSDI Mental Health Consultant.	Street Address	City	State	Zip Code
Sharon Rinearson	1590 Laurel Park Court	Orange City	FL	32763

Patient Authorization

I, the undersigned, request a release to New Horizons Service Dogs any requested information regarding my condition. The information given will not be used for any other purpose than to evaluate and assess my situation in making a successful Service Dog placement and assisting me with ancillary services. New Horizons Service Dogs will keep this information confidential and will not share it with anyone but the professional staff of any agency that is involved in helping provide services for me.

I have read and understand the above information and give my authorization: *(please check boxes below)*

- ☐ To release any applicable mental health information to New Horizons Service Dogs
- ☐ To release an applicable substance abuse information to New Horizons Service Dogs

Patient Signature	Date

NOTICE TO RECIPEINT(S) OF INFORMATION:
Information disclosed to you pertaining to certain conditions, such as treatment for alcohol or drug abuse, HIV/AIDS and other sexually transmitted diseases, behavioral health, and genetic marker information is protected by various federal and state laws which prohibit any further disclosure of this information by you without the express written consent of the person to whom it pertains or as otherwise permitted by such laws. Any unauthorized further disclosure in violation of state or federal law may result in a fine or jail sentence or both. A general authorization for the release of medical or other information is NOT sufficient consent for release of these types of information. The federal rule at 42 CFR Part 2 restricts use of the information disclosed to criminally investigate or prosecute any alcohol or drug abuse patient.

Mental Health Professional-Medical History

Provider Use ONLY:

Applicant's Name:_____ DOB: _____

Mental Health Provider Name			Telephone Number	Fax Number
Practice Name	Street Address	City	State	ZIP code

Qualifications/License:	Initial Intake Date and Treatment Recommendations:

Date of last examination: _____

Length of time with client: _____

Frequency of sessions: _____

Official Diagnosis of Applicant (Attach additional sheet if necessary)

_____
_____
_____
_____
_____

Summarize the state of applicant's mental health and your treatment plan (ongoing treatment plan, duration and frequency):

_____
_____
_____
_____

Please indicate what strategies applicant uses for managing anger issues:

_____
_____
_____
_____

Is applicant actively suicidal? (Describe) _____Yes _____No

_____
_____
_____
_____

Is the applicant's family and/or support network in support of applying for a service dog?

_____
_____
_____
_____

In your opinion is the applicant able to actively participate in the two-week team training required and to take on its level of Commitment?

_____
_____
_____
_____

Medications and dosage:

_____
_____
_____
_____

Medical/Emotional Evaluation of Client:

Able to exercise judgment for ADL?	Yes	Minimally	No
Able to sustain attention span?	Yes	Minimally	No
Able to control physical or motor movement sufficient to sustain ADL?	Yes	Minimally	No
Capable of perception and memory to the degree necessary to sustain ADL?	Yes	Minimally	No
Able to follow directions and learn to sustain ADL?	Yes	Minimally	No
Under any medications which impar functioning?	Yes	Minimally	No
Capable of decisions about personal or others' needs and safety?	Yes	Minimally	No
Manifesting inappropriate behavior beyond his/her control. (Give examples below)	Yes	Minimally	No

_____
_____
_____
_____
_____

Specific Triggers for PTSD Reactions:

_____
_____
_____
_____
_____

Specific PTSD Behaviors that the organization should know and train for concerning:

Dissociation:

_____
_____
_____
_____

Loss of memory:

Anger/Irritability:

Inability to regulate emotions:

Loss of concentration:

Experiencing Flashbacks:

Nightmares:

Hypervigilance or Paranoia:

Insomnia:

Exaggerated Startle Response:

Risky behavior:

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Any other comments that would help us to determine the readiness and fit for the program? *(Additional space on next page)*

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Mental Health Provider's signature:____ Date: _____________________

Would you like New Horizons to contact you directly regarding this client: _____________Yes ________________No

Please return the completed Medical History form to New Horizons Service Dogs, 1590 Laurel Park Court, Orange City, FL 32763, by fax to (386) 456-0409, by email to education@nhsdi.org

Additional Notes: