



Riding On Angels' Wings

Therapeutic Horseback Riding

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I _____ authorize _____ to
(Parent/Guardian) (Agency Name)

release confidential information regarding _____
(Participant Name)

to Riding On Angels' Wings – Therapeutic Horseback Riding Program, Felton, MN.

Medical Information _____

Therapy or School/Goals & Objectives _____

Other _____

Comments:

Signature: _____
(Parent / Guardian)

Date: _____

This release is good for 1 year from the signature date.