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| <p style="text-align: center;"><b>PAWS<br/>FOR LIFE<br/>USA</b></p> | <p style="text-align: center;"><b>Psychiatric Service Dog</b></p>  <p style="text-align: center;"><b>Mental Health Consent Form</b></p> |  |
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### Paws For Life USA Consent to Release Information

We ask that you sign our consent to release information form as part of our processing of your application for a Service Dog. This authorization shall become effective immediately and shall remain in effect for a three-year period from the date it was signed.

This is to authorize any physician, hospital, firm, organization or person to have direct communication with Paws For Life USA (hereinafter referred to as “PFLUSA”), regarding all information, material or opinions which may be requested by PFLUSA concerning me.

By signing below, I am giving my licensed mental health provider (Masters level and above) explicit permission to communicate directly with PFLUSA about my mental health.

PFLUSA is further authorized to copy any records pertaining to me. I hereby waive any privilege I have to said information to PFLUSA, and agree to hold PFLUSA nameless from any claims as a result of the sharing of information related to me.

The information received by PFLUSA, will only be used to evaluate my application for a service dog and the dogs subsequent training with me.

I understand that any information provided to PFLUSA will remain confidential.

Applicant’s Signature \_\_\_\_\_ Date \_\_\_\_\_

First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Email: \_\_\_\_\_ Phone: \_\_\_\_\_

Legal Caregiver’s signature (if applicable): \_\_\_\_\_ Date \_\_\_\_\_

First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Email: \_\_\_\_\_ Phone: \_\_\_\_\_