



**SHADOW MOUNTAIN  
MEDICAL RELEASE**

To: Health Care Provider

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

Phone Number: \_\_\_\_\_ Fax Number: \_\_\_\_\_

Patient / Client: \_\_\_\_\_

I, \_\_\_\_\_ (Applicant or Parent if Applicant is under the age of 18), hereby authorize all healthcare providers, or other covered entities to disclose to Shadow Mountain officers, agents, or employees, upon request, any information, oral or written, regarding the physical or mental health of \_\_\_\_\_ (Applicant), including, but not limited to, medical and hospital records, including what is otherwise private, privileged, protected or personal health information, including but not limited to, health information as defined and described in the Health Insurance Portability and Accountability Act of 1996 (Public Law 104-191, 100 Stat. 2024), as amended, the regulations promulgated thereunder and any other state or local laws and rules. Information disclosed by a healthcare provider or other covered entity may be redisclosed for treatment purposes and may no longer be subject to the privacy rules provided by 45 CFR § 164. Xeroxed or fax copies of this release shall be deemed sufficient as an original

\_\_\_\_\_  
Student Signature and Date

\_\_\_\_\_  
Parent / Guardian Signature and Date

State of \_\_\_\_\_ )  
County of \_\_\_\_\_ ) s.s.

Subscribed and sworn to before me by

\_\_\_\_\_ this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_\_

NOTARY PUBLIC

My commission expires: \_\_\_\_\_



**SHADOW MOUNTAIN  
MEDICAL RELEASE, CONTINUED**

Please provide the following information about the patient listed above.

Current Medical Condition:

Current Diagnosis:

Allergies:

Allergies to Medications:

Current Medications Prescribed:

Medication	Dosage / Time Taken	Prescribed For
1		
2		
3		
4		
5		

Other Medications in the Past Year:

Medication	Dosage / Time Taken	Prescribed For
1		
2		
3		
4		
5		

Summary of Intended Future Treatment, Duration, Recommendations:

\_\_\_\_\_  
Prescribing Doctor Signature

\_\_\_\_\_  
Date





**SHADOW MOUNTAIN  
PHYSICAL FITNESS / ACTIVITIES RELEASE**

The Applicant/Parent agree that the Shadow Mountain curriculum offers various physical and recreational activities, educational and vocational components on and off campus as part of the program. Certain activities may also be somewhat strenuous and carry with them inherent risk of injury. Students will be encouraged to participate in all activities and do so at their own risk.

The Applicant/Parent hereby consents to the Applicant's participation in all activities and programs conducted by Shadow Mountain, and releases Shadow Mountain Academy, LLC., its agents, employees and officers, from all claims, demands, action, judgments and executions which the undersigned may have against Shadow Mountain for all personal injuries, known or unknown, and injuries to property, personal or real, caused by or arising out of the Applicant's participation in the related activities and programs. This release and discharge further extends to any injury caused as a result of the Applicant's decisions or actions, made while enrolled as a client or not.

\_\_\_\_\_  
Applicant Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Parent Signature

\_\_\_\_\_  
Date