# 2025 We Can Ride Authorization for Treatment and Photo Release

Client's Name: _____ DOB:_____Phone: _____

Address: _____

Clinic Phone: _____Preferred Medical Facility: _____

Health Insurance Co.: _____Policy #: _____

Allergies to medications: _____

Current medications: _____

Please list two people who may be contacted in case of emergency (these may include guardian)

Name: _____Relation:_____Phone:_____

Name: _____Relation:_____Phone:_____

In the event emergency medical aid/treatment is required due to illness or injury during the process of receiving services or while being on the property of the agency, I authorize *We Can Ride, Inc.* to:

1. Secure and retain medical treatment and transportation if needed.
2. Release client records upon request to the authorized individual or agency involved in the medical emergency treatment.
3. To take all other reasonable measures to secure medical aid for the emergency.

## Photo Release

**Circle one**: I hereby **do consent / do not consent** to and authorize the use and public distribution of any and all photographs of myself or others for whom I am authorized to give consent, including the use of audio/visual materials for promotion, education or exhibition or any other use to benefit *We Can Ride, Inc.*

**********

I have read, and understand all the material in this document. I hereby consent and agree to the conditions set forth herein.

Signature of Release ✗_____ Date _____

Client, Parent or Guardian