

CONSENT TO CONTACT AND AUTHORIZATION FORM

New Life K9s and its mental health consultant may communicate directly with the professionals below for the purpose of evaluating my application to receive a Service Dog. I authorize the individuals below to release the information requested, including private or protected information, to New Life K9s. This authorization shall remain in effect until my application is withdrawn or denied, or if my application is neither withdrawn nor denied, until the retirement of the Service Dog I received from New Life K9s.

AUTHORIZED PROFESSIONALS:

Primary Doctor

Phone Number

Address

Email

Mental Health / Psychologist/ Psychiatrist

Phone Number

Address

Email

Additional Provider Name

Phone Number

Address

Email

Veterinarian

Phone Number

Address

Email

Applicant Signature and Date