Everyone deserves to live a life of meaning

CONSENT TO RELEASE INFORMATION

I hereby give permission for Farm of Hope Inc./Hope Springs Farm to receive all relevant medical and personal information, from any service provider listed in the Individual Support Plan, Family member or Guardian, including my Physicians.

I also hereby give permission for Farm of Hope Inc./Hope Springs Farm to provide all relevant medical and personal information including attendance and billing data, to any service provider listed in the Individual Support Plan, Family member or Guardian, including my Physicians.

Individual's Printed Name: ____

Individual's Signature: ____

Date: _________________________

Signature of Family Member or Guardian: ___________________________________

Relationship to Individual: ____

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GROWER INTAKE CONTACT INFORMATION FORM

Grower Name: ____

***Supports Coordinator Name*:** ____

Phone Number: ____

Email: ____

County: ____

Contact #1:

Name: ____

Address: ____

Phone Number: ____

Email: ____

Relationship to Grower: ____

Contact #2:

Name: ____

Address: ____

Phone Number: ____

Email: ____

Relationship to Grower: ____

Contact #3:

Name: ____

Address: ____

Phone Number: ____

Email: ____

Relationship to Grower: ____