RELEASE AND ACKNOWLEDGMENT OF RISK

I understand and acknowledge that Blossom Therapeutics, LLC, an Oregon limited liability company ("**Blossom**") provides use of its leased facilities to independent contractors, including Blossom Therapeutics, LLC ("**Provider**") for Provider's therapy or other health care services (the "**Activity**"). The Activity presents known and unknown risks that could result in injury, death, illness, or other damage to my child or other legal ward ("**Participant**"), myself, or to my property.

I acknowledge that (*enter Participant's name*) _____ is physically capable of participating in the Activity.

I understand that my sole recourse is against Provider for any and all liabilities, claims, demands, or actions for injury or death to Participant, myself, to others, or injury to my property, or which are in any way connected with Participant's participation in the Activity.

I hereby voluntarily release, forever discharge, and agree to hold harmless and indemnify Blossom and Provider, and all other persons or entities involved with the Activity, including the members, managers, agents or employees of Blossom and Provider, from any and all liabilities, claims, demands, or actions for injury or death to Participant, to myself, to others, or injury to my property, or which are in any way connected with Participant's participation in the Activity, other than for gross negligence or willful misconduct by such persons or entities.

THIS IS A RELEASE

My signature below indicates that I have read this release and acknowledgement of risk and understand it completely. I UNDERSTAND THAT BY SIGNING THIS DOCUMENT I LIMIT MY RIGHT TO MAKE A CLAIM OR FILE A LAWSUIT FOR INJURY TO ME, MY CHILD (OR OTHER LEGAL WARD) TO OTHERS, OR TO MY PROPERTY. NEVERTHELESS, I ENTER INTO THIS AGREEMENT FULLY AND VOLUNTARILY AND AGREE THAT IT WILL BE BINDING UPON ME, MY HEIRS, ASSIGNS AND LEGAL REPRESENTATIVES. I FURTHER AGREE THAT IF ANY PART OF THIS AGREEMENT IS UNENFORCEABLE, THE REMAINDER SHALL CONTINUE TO BE EFFECTIVE TO THE MAXIMUM EXTENT PERMITTED BY LAW.

Signature of Participant's Parent (or Guardian): _____

Name of Participant's Parent (or Guardian): _____

Date: _____, 20__

AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

If you choose to sign this Authorization, you are granting Provider permission to share certain protected health information about Participant. Provider may not condition treatment, payment, enrollment or eligibility for benefits on your signature of this Authorization.

I authorize Provider to disclose (in accordance with the Health Insurance Portability and Accountability Act of 1996 and the regulations thereunder ("**HIPAA**")), to the parties listed below, protected health information that relates directly or indirectly to Participant's therapy or other health care. The foregoing protected health information may be disclosed to (*specify*): ____ Blossom Therapeutics, LLC, Therapy Northwest, P.C., Saul Behavior and any employees or agents of any of these parties _____
_____
_____.

This authorization is intended to provide Provider with the authorization necessary to allow them to disclose protected health information regarding Participant to the persons described in the paragraph above for the purpose of allowing each of them to provide therapy or other health care to Participant.

Information disclosed by Provider pursuant to this authorization is subject to redisclosure and may no longer be protected by the HIPAA privacy rules of 45 CFR Part 164.

This authorization may be revoked by a writing signed by me.

This authorization will expire three years after the date below, unless validly revoked prior to that date.

Signature of Participant's Parent (or Guardian): _____

Name of Participant's Parent (or Guardian): _____

Date: _____, 20__