

AUTHORIZATION TO OBTAIN OR RELEASE INFORMATION

Student's Full Name	Date of Birth
Parent or Guardian	Date

I authorize the following entities to exchange verbal and/or written information about my child's needs and services received.

1. Name of Individual/Agency to Obtain or Release Information	Relationship to Child	
Midwest Academy	School	
Address	City, State	Zip
1420 Chase Court	Carmel, IN	46032
Phone		
(317) 843-9500		

2. Name of Individual/Agency to Obtain or Release Information	Relationship to Child	
Address	City, State	Zip
Phone	Email	

The information obtained or released may include:	
<input type="checkbox"/> Initial assessment/evaluation <input type="checkbox"/> IEP/ISP <input type="checkbox"/> Testing Records <input type="checkbox"/> School Records (specify) _____ <input type="checkbox"/> Consultation Reports (specify) _____ <input type="checkbox"/> Other (specify) _____	<input type="checkbox"/> Phone Calls <input type="checkbox"/> Discharge Summary <input type="checkbox"/> Progress Notes

Purpose:	<input type="checkbox"/> Assist with my child's care <input type="checkbox"/> Other (specify) _____
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This authorization to obtain or release information is valid for information already in existence and for any information that may be generated while this authorization is effective.

I understand that I can revoke my authorization at any time. I understand that the revocation will not apply to information that has already been released in response to this authorization. Unless otherwise revoked, this authorization shall expire on the date specified below. If I fail to specify an expiration date, this authorization will expire in twelve months after the date it is signed.

I understand that this authorization is voluntary. I do not need to sign this form to be assured educational services or health care treatment.

Signature	Date

Printed Name	Relationship to Client

THIS AUTHORIZATION EXPIRES ON:	
Date:	

REQUEST TO REVOKE
Authorizing Signature: _____ Date: _____