Midwest Academy®

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

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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:	
☐ Initial assessment/evaluation	☐ Phone Calls
☐ IEP/ISP	☐ Discharge Summary
☐ Testing Records	☐ Progress Notes

☐ School Records (specify) _____

☐ Consultation Reports (specify) _____

☐ Other (specify) _____

Purpose:	☐ Assist with my child's care ☐ Other (specify) _____

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: _____