Midwest Academy®
Engaging minds. Inspiring futures.

AUTHORIZATION TO OBTAIN OR RELEASE HEALTH CARE INFORMATION

Student Name:		Date of Birth:	
Parent or Guardian		Date	

I authorize the following individual or agency to share written or oral information about my child's needs and services received:

Name of agency to release and receive information	Midwest Academy
Address	1420 Chase Court
City/State/Zip Code	Carmel, IN 46032
Phone	317 843 9500

With the following individual or agency:

Name of agency to release and receive information	
Address	
City/State/Zip Code	
Phone	

The information shared or released may include:

☐ Initial assessment/evaluation ☐Progress notes ☐ Discharge summary

☐ IEP ☐ Phone calls

☐ Consultation report (specify) _____

☐ School records (specify) _____

☐ Other (please specify) _____

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

This authorization is valid for information already in existence and 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, the authorization shall expire on the date specified below. If I fail to specify an expiration date, this authorization will expire in six 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 treatment.

Authorizing signature: _____

Date: _____ Relationship to client: _____

This authorization will expire on: _____

Request to revoke:

Signature: _____

Date: _____