



**Consent to Release Protected
Educational, Mental/Physical Health and Legal Information**

Student's Name

Date of Birth

*I authorize and request, the free oral and/or written exchange of the following protected
Educational, Mental/Physical Health and Legal Information regarding the student named above:*

- | | | |
|---|---|---|
| <input type="checkbox"/> Individualized Educational Plans(IEP) | <input type="checkbox"/> Therapeutic Summaries | <input type="checkbox"/> Psychiatric Reports |
| <input type="checkbox"/> Educational Reports and information | <input type="checkbox"/> Progress Reports and info. | <input type="checkbox"/> Discharge Summaries |
| <input type="checkbox"/> Disciplinary Reports | <input type="checkbox"/> Psychological Evaluations | <input type="checkbox"/> Medical/Physical Forms |
| <input type="checkbox"/> Social History | <input type="checkbox"/> Legal/Court Reports | <input type="checkbox"/> Hearing/Vision Reports |
| <input type="checkbox"/> Monthly Progress notes to Prescribing MD's | <input type="checkbox"/> Other: _____ | <input type="checkbox"/> Other: _____ |

This information will be released from:

Phone: _____
Fax: _____

South Campus
909 E. Wilmette Rd. Ste F
Palatine, IL 60074
Phone: (847)359-8300
Fax: (847) 359-8301

TO

AND

Your Child's Home School District: _____

This information will be released from:

South Campus
909 E. Wilmette Rd. Ste F
Palatine, IL 60074
Phone: (847)359-8300
Fax: (847) 359-8301

TO

Phone: _____
Fax: _____

AND

Your Child's Home School District: _____

I understand that this authorization will be valid from the date of signature, until September 30th of the following academic year (not to exceed 12 months). It is limited to only the information designated above, which will be released from, and to, only the individual(s), agencies and school(s) named herein. The purpose of this release of information is to assist in providing continuity of care. I understand that I have the right to inspect and copy the information disclosed. I understand that my refusal to consent to the release of the information specified above will prevent disclosure of such material to the individual(s) and school(s) named herein, with the potential consequence of reduced accuracy and quality/completeness of care provided. I understand that I have the right to revoke the consent contained here in. This revocation must be in writing.

Signature of Parent

Date

Signature of Student (if 12 years or older)

Date

Witness

Date