

Authorization for Release of Information

Student : _____ Date of Birth: _____

Address: _____ City, State, Zip: _____

Phone Number: _____

I authorize South Seneca School
to release information to:

AND/OR

I authorize South Seneca School
to obtain information from:

Name of Provider or Facility

Name of Provider or Facility

Address

Address

City, State, Zip Code

City, State, Zip Code

Phone #/Fax # (Include area code)

Phone #/Fax # (Include area code)

PURPOSE OF THIS REQUEST: (check one) Counseling Medical Info. Personal Other

TYPE OF RECORDS AUTHORIZED: Psychiatric/Psychological Evaluation and/or Treatment
 Drug/Alcohol Evaluation and/or Treatment

SPECIFIC INFORMATION AUTHORIZED: (select one or more as appropriate)

Assessments Progress Notes Laboratory Test Results: _____

Diagnostic Impression Discharge Summary Treatment Plans

Treatment Summary

Other: (please describe) _____

Periodic Use/Disclosure: I authorize the periodic use/disclosure of the information described above to the person/provider/organization/facility/program(s) identified as often as necessary to fulfill the purpose identified in this document.

Signature of Student or Representative: _____ Date: _____

Relationship to Student (if requester is not the student): Parent Legal Guardian Other: _____