Communication Authorization Form/Release of Healthcare Information

Student's Name:				
Address:	City:		State:	Zip Code:
Phone:	DOB:			
Ι,		authorize.		
I, to: (send) (receive) the follow	ving (to)	(from)		
Name:				
Address:	City		State:	Zip Code
Academic testing resu	ılts		Progress	
Behavioral programs				ogical reports
Intelligence testing re	sults		Summar	
Medical reports			Other, sp	ecify:
The purpose of this request is:				1.
At the request of the individual				ed treatment
Treatment planning			Other, sp	ecify:
			D .	
Client's Signature: Parent/Guardian's Signature:			Date:	
Parent/Guardian's Signature:			Date:	
Witness' Signature:			Date:	
I, to: (send) (receive) the follow	, autho	rıze		
to: (send) (receive) the follow	ving (to)	(from)		
Name:		Q	7:	C- 1-
Address: Ci	ty	State:	Zır	Code
Academic testing resu	ilts		Progress	reports
Behavioral programs				ogical reports
Intelligence testing res	sults		Summar	
Medical reports			Other, sp	ecify:
The purpose of this request is:				
At the request of the individual				ed treatment
Treatment planning			Other, sp	ecify:
Client's Signature: Parent/Guardian's Signature: Witness' Signature:			Date:	
Parent/Guardian's Signature:			Date:	
Witness' Signature:			Date:	
	-			
I understand that this authorization I am provi	ding today is vo	luntary, and tha	t I may revoke this	s consent at any time by providing writt
notice, and after 1 year this consent automatic Authorization Form is confidential, and will n	ally expires. I h	ave been inform	ned that informati	on provided through this Communication with a parental figure(s)/legal guardian with
three noted exceptions: information received	that is abuse an	d/or neglect rel	ated must be repor	ted to the proper state agencies, legal c
related requests for information must be provi	ded, and court r	elated testimon	v about provided ir	nformation must be given if involved in
court/legal proceedings. I have been informed	d what informati	on will be give	n, its purpose, and	who will receive the information. I
understand that I have a right to receive a cop	y of this form if	desired.		
Authorizing individual:			Date:	
Witness:		Date:		