THE WOODSTOCK ACADEMY
57 Academy Road
Woodstock, CT 06281
Phone: (860) 928 – 6575 Fax: (860) 963 – 7222

AUTHORIZATION TO OBTAIN AND RELEASE INFORMATION

I, _____, hereby authorize The Woodstock Academy

to **OBTAIN and RELEASE** the following information regarding myself/child (please write name of child)

_____,

from (complete name and address): _____

_____

_____

for the specific purpose of coordination of educational services.

Please ***initial*** the following item(s) to be released:

_____ Educational Record	_____ Summary of Mental Health Treatment
_____ Treatment Plan	_____ Discipline/Attendance Record
_____ Dates of Treatment Admission/Discharge	_____ Discharge plan (including Diagnosis)
_____ Medical	_____ Psychological Evaluation
_____ Special Education and Test Records	_____ Coordination of Services

Date of Birth: _____Social Security Number: _____ (if needed)

The confidentiality of this record is required under Chapter 899 of the Connecticut General Statutes as well as Title 42 of the United States Code. This material should not be transmitted to anyone without the client's written consent or authorization as provided for in these statutes.

I understand that I may revoke this consent at any time unless it has already been executed. This consent, if not revoked, *will expire 365 days from date of signature of consent*. Otherwise, it will expire on: _____.

_____ _____
Signature of Parent/Guardian Date

_____ _____
Signature of Witness Date

_____ _____
Signature of Student (16 years or older, 14 or older for substance abuse) Date