

The Woodstock Academy

57 Academy Road
Woodstock, CT 06281
(860) 928-6575

AUTHORIZATION FOR RELEASE OF INFORMATION

I, _____, hereby authorize The Woodstock Academy to

OBTAIN and/or 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 check the following items to be released:

- | | |
|---|---|
| <input type="checkbox"/> Educational Record | <input type="checkbox"/> Summary of Mental Health Treatment |
| <input type="checkbox"/> Treatment Plan | <input type="checkbox"/> Discipline / Attendance Record |
| <input type="checkbox"/> Dates of Treatment Admission/Discharge | <input type="checkbox"/> Discharge Plan (including Diagnosis) |
| <input type="checkbox"/> Medical | <input type="checkbox"/> Psychological Evaluation |
| <input type="checkbox"/> Special Education and Test Records | <input type="checkbox"/> Coordination of Services |

Birthdate: _____ 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 in 365 days from date of signature of consent, otherwise specify

_____.

(Date, Event, or Condition)

Signature of Parent/Guardian

Date

Signature of Witness

Date

Signature of Student if student is 16 years or older

Date