The Woodstock Academy
57 Academy Road89
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:

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

Birthdate: _______________ Social Security Number: _________________________________ (if needed)

The confidentiality of this record is required under Chapter899 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

SUBSTANCE ABUSE RECORDS REQUIRE SIGNATURE OF ALL STUDENTS 14 YEARS AND OLDER