



ST. FRANCIS HIGH SCHOOL
COLLEGE PREPARATORY

AUTHORIZATION FOR RELEASE OF INFORMATION

Student Name: _____ DOB: _____

• **I GIVE MY PERMISSION FOR:**

 (Doctor, Hospital, Therapist or Program)

 (Address)

 (Address)

• **TO RELEASE INFORMATION TO OR FROM THIS/THESE AUTHORIZED PERSON(S) AT ST. FRANCIS HIGH SCHOOL:**

 Person(s) and Extension(s)

• **SPECIFIC INFORMATION TO BE DISCLOSED:**

- | | |
|-----------------------------------|------------------------------------|
| _____ Initial Evaluation | _____ Social History |
| _____ Psychological Testing | _____ Treatment Summary |
| _____ Medical Evaluation/Tests | _____ Observations/Recommendations |
| _____ Educational Information | _____ Clinical Impression |
| _____ Other Pertinent Information | _____ All of the Above |
| _____ Other _____ | |

• **FOR THE PURPOSE OF:**

- _____ Ongoing Treatment Services
 _____ Consult with Therapist
 _____ Psychological Evaluation
 _____ Psychiatric Consultation
 _____ All of the Above
 _____ Other _____

I understand the reasons for the release of this information and have been informed of the benefits or disadvantages associated with such release. It is understood that the person authorizing release of this information has the right to inspect and copy information to be disclosed and that this information will not be redisclosed without proper authorization.

 (Date)

 (Patient Signature)

 Parent(s)/Guardian(s) Signature(s)