Connection's Day School

Consent to Release Protected Educational, Mental/Physical Health and Legal Information

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Student's Name **Date of Birth**

I authorize, and request, the free oral and/or written exchange of the following protected Educational, Mental/Physical Health and Legal information regarding the student named above:

- ☐ Individualized Education Plans (IEP)
- ☐ Educational Reports and Information
- ☐ Disciplinary Reports
- ☐ Social Histories
- ☐ Monthly Progress Reports to Prescribing MDs
- ☐ Therapeutic Summaries
- ☐ Progress Reports and Information
- ☐ Psychological Evaluations
- ☐ Legal/Court Reports
- ☐ Other: ______________________
- ☐ Psychiatric Reports
- ☐ Discharge Summaries
- ☐ Medical/Physical Forms
- ☐ Hearing/Vision Reports
- ☐ Other: ______________________

This information will be released from:

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Phone: ______________________________

Fax: ______________________________

TO

Connection's Day School
31410 Highway 45
Libertyville, IL 60048
Phone: (847) 680-8349
Fax: (847) 680-8583

AND

Your Child's Home School District: ______________________________

This information will be released from:

Connection's Day School
31410 Highway 45
Libertyville, IL 60048
Phone: (847) 680-8349
Fax: (847) 680-8583

TO

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Phone: ______________________________

Fax: ______________________________

AND

Your Child's Home School District: ______________________________

I understand that this authorization will be valid from the date of signature, until September 30th of the following academic year (not to exceed 12 months). It is limited to only the information designated above, which will be released from, and to, only the individual(s), agencies and school(s) named herein. The purpose of this release of information is to assist in providing continuity of care. I understand that I have the right to revoke this consent at any time by submitting such a request in writing. I also understand that I have the right to inspect and copy the information disclosed. I understand that my refusal to consent to the release of the information specified above will prevent disclosure of such material to the individual(s) and school(s) named herein, and, as such, may reduce the accuracy and quality/completeness of care provided.

______________________________ ______________________________

Signature of Parent **Date**

______________________________ ______________________________

Signature of Student (if 12 years or older) **Date**

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Witness **Date**