Connections Day School
31410 North US Highway 45 | Libertyville, IL 60048
Phone: 847.680.8349 | **Fax:** 847.680.8583 | **Web:** www.connectionsdayschool.net

CONSENT TO RELEASE
EDUCATIONAL, MENTAL/PHYSICAL HEALTH AND LEGAL INFORMATION

_____ _____
Name **Date of Birth**

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

☐ Educational Reports & Information (e.g., individualized education plans (IEP); social/developmental histories; progress reports & information; disciplinary reports; IWAS/SIS data)

☐ Mental Health Information (e.g., therapeutic summaries; psychological evaluations; psychiatric reports; monthly progress reports to physicians, substance abuse evaluations and progress notes)

☐ Medical Reports & Information (e.g., medical/physical forms/reports; laboratory results)

☐ Re-release of records from physicians, mental health professionals, hospitals, partial hospitalization programs, and outpatient treatment programs which were obtained during the time the student was enrolled at our school

TO/FROM:

Name: _____

Address: _____

City, State, Zip: _____

Phone: _____ **Fax and/or E-Mail:** _____

AND

Your Child's Home School District and its Agents

I further authorize the home school district and the agency/person listed above to release all said information to Connections Day School.

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. I authorize the information to be released via e-mail, knowing there are risks to confidentiality in the use of e-mail.

_____ _____
Signature of Parent/Guardian **Date**

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

_____ _____
Witness **Date**