

**AUTHORIZATION FOR RELEASE OF RECORDS AND COMMUNICATIONS**

I, \_\_\_\_\_, \_\_\_ client \_\_\_ parent \_\_\_ legal guardian \_\_\_ "primary caretaker",  
authorize \_\_\_\_\_ to: \_\_\_ release the records marked below  
Institution/Agency/Practitioner

for inspection and/or copying by, and/or \_\_\_ communicate with, the recipient(s) noted below  
regarding \_\_\_\_\_, \_\_\_/\_\_\_/\_\_\_, for the purpose of: \_\_\_\_\_  
Client/Student Birth Date

Recipient(s) \_\_\_\_\_ ( ) \_\_\_\_\_,  
Name & Title Phone

Agency, Street Address, City, State, Zip Code

This consent is valid until \_\_\_/\_\_\_/20\_\_\_, unless revoked by me in writing, delivered to: \_\_\_\_\_

<b>RECORDS TO BE RELEASED</b>			
The records released shall cover the dated of ___/___/___ to ___/___/___ (Optional)			
<u>Evaluation/Assessment</u>	<u>Treatment</u>	<u>Education Records</u>	
___ Psychological Report	___ Treatment Plan	___ Grades/Transcript	___ Attendance
___ Social Work Report	___ Treatment Records	___ Health Records	___ Discipline Records
___ Psychiatric Report	___ Progress Reports/Summaries	___ Test Scores	___ IEP/504 Plan
___ Educational Testing		___ Speech, OT, PT Reports	___ Behavior Mgt. Plan
___ Reports/Evaluations received from _____ Institution/Agency/Independent Practitioner			
___ Other _____			

Mental Health Records: I fully understand the nature and purpose of the authorization, that I have the right to inspect and copy the records to be released, and that I may revoke this consent at any time. The consequences, if any, of my refusal to consent to the release of these records have been explained to me as:

School Records: I understand that I have the right to inspect, copy, and challenge the content of the school student records for which I am authorizing release. I also have the right to designate the school student records to be released or to identify specific portions of a school record to be released by this consent. Any such limitations have been noted above.

Authorized Signature \_\_\_\_\_ Date \_\_\_\_\_

Signature of Minor over the Age of 12 (Mental Health Records) \_\_\_\_\_ Date \_\_\_\_\_

Signature of Witness (Mental Health Records) \_\_\_\_\_ Date \_\_\_\_\_

Note to Agent/Person Receiving Records. Under the provision of the Mental Health and Developmental Disabilities Confidentiality Act, 740 ILCS 110/5(d), the Federal Education Rights Privacy Act, 34 CFR 99.33(a), and the Illinois School Student Record Act, 105 ILCS 10/6(d) you may not redisclose any of the information without first obtaining specific written consent conforming with the appropriate Act.  
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