MACNEAL SCHOOL—AUGUST 2011-AUGUST 2012

AUTHORIZATION FOR RELEASE OF INFORMATION

Student's Name _____ Date of Birth ____/_____/_____

The undersigned hereby authorizes and requests MacNeal School to exchange information with:

_____	_____
Individual or Organization	**Telephone**
_____	_____
Street Address	**Pager**
_____	_____
City, State, Zip Code	**Fax**

The information released includes only the following information:

_____ Legal	**_____ Vocational**
_____ Health/Medical	**_____ Educational**
_____ Psychiatric/Psychological	**_____ Other (Please Specify)**

The purpose of this release of information is for the coordination of educational and support services.

This authorization is valid for the school year 2009-2010, unless otherwise specified.

I fully understand the following conditions:

1. The record and/or information that is to be released herein is privileged and confidential and may be released only by proper authorization, except as required by law.
2. I have the right to revoke this authorization at any time by submitting a written revocation to MacNeal School.
3. A copy of this authorization is as valid as the original.

_____	_____
Parent/Guardian Signature	**Date**
_____	_____
Signature of Student (if over 12 years of age)	**Date**
_____	_____
Witness	**Date**