

INNER HARBOUR

Authorization For Release Of School Information

PATIENT NAME: _____ DOB: _____ MED.REC.# _____

I request and authorize: INNER HARBOUR

To obtain from:

Lisa Ayers SCHOOL RECORDS

(Person or Agency Requesting Information)

(Person or Agency Releasing Information)

4685 Dorsett Shoals Road

(Address)

(Address)

Douglasville, GA. 30135

(City, State, Zip)

(City, State, Zip)

770-942-2391/ 770-489-0406

(Phone Number/Fax Number)

(Phone Number/Fax Number)

PLEASE SEND ALL APPLICABLE RECORDS:

Immunization Records

Due Process Check List & Transition Plan

Psychological Evaluation & Testing

Transcript/Withdrawal Grades

Eligibility Report

Psychiatric History

I.E.P.

Vision & Hearing Screening

Psychiatric Social History

Total Service Plan Including Objectives

Consent for Placement

Treatment Plan

Consent(s) to Evaluate

Placement Minutes

This document serves as an open communication release for both parties to exchange information regarding student progress and placement. I understand that this information may be sent via fax machine.

All information I authorize to be obtained from the releasing person/agency will be held strictly confidential and cannot be released by the recipient without my written consent. I understand that this authorization will remain in effect for:

(check one) 90 days upon discharge earlier date: _____

I understand that unless otherwise limited by state or federal regulation, and except to the extent that action has been taken which was based on my consent, I may withdraw this consent at any time.

Date Signed: _____ Patient Signature: _____

This information has been disclosed to you from records whose confidentiality is protected. Any further redisclosure is strictly prohibited.

Parent/Legal Guardian: _____

Witness: _____

I withdraw my consent to the release of information: _____
(Signature & Date)

4685 Dorsett Shoals Road
Douglasville, GA. 30135
(800) 255-8657 or (770) 942-2391