School Year 2015-2016

AUTHORIZATION FOR THE RELEASE OF CONFIDENTIAL INFORMATION

To:___________________________
@ Laraway School PO Box 621 Johnson VT 05656

From:___________________________

Regarding:________________________________**DOB**_______________

Please Check all that applies:

_____**Counselor** _____ **Mental Health Agency** _____ **Previous School**

_____ **Other - Please list**____

____

_____ **Authorization to *Send* Information**
I authorize Laraway School, Inc. to release information pertaining to my education evaluation and / or treatment including treatment for substance abuse for the time period(s)__________________to the individual, agency, or program checked above.

_____**Authorization to *Receive* Information**
I authorize you to release information pertaining to my education, evaluation, and/or treatment including treatment for substance abuse for the time period(s)__________________________ to Laraway School, Inc. at the above address.

I understand that, by law, I need not consent to the release of this information. However, I choose to do so for the purpose of facilitating my education, evaluation, and treatment and/or for the following purpose(s)____

I understand that I may revoke this consent at any time, except to the extent that action based on it has already begun. Revocation of this consent requires written notification. In any event, this authorization to release information expires one year from the date of discharge from Laraway School or on the following earlier date_____________________________________.

Having read and understood this form, I release the above listed persons or agencies/programs/hospitals from any liability arising from release of this information, providing the information is released in accordance with applicable law.

Date_______________ Signature__________________________(Parent/Guardian)

Date_______________ Signature__________________________(Witness)

Date_______________ Signature___________________________Laraway School Director