

RELEASE OF INFORMATION - ADOLESCENT

Student's Full Name _____ Date of Birth _____

I/We authorize the following individuals and/or organizations to release and/or receive from and/or to exchange all information (including medical information, academic information, specific information approved below and/or photos) concerning the above named Student to / from Fresh Tracks Educational Consulting and its staff. **Please list doctors, therapists, educational consultants, medical and mental health professionals and other individuals with whom we may need to communicate.** Please enter all requested information; use additional pages if needed.

I/We understand that types of disclosures may include: Verbal and/or written communications, Psychosocial, Psychological and/or Neuropsychological reports, copies of records and discharge summaries, proof of attendance, academic records or medical files.

I/We acknowledge and authorize the release of information related to **(Please check ALL 4 boxes to ensure adequate communication and acknowledgement):**

Mental Health Substance Abuse Communicable Diseases HIV/AIDS

The purpose of this release is at the request of the student/legal guardian (if under 18) for Fresh Tracks Educational Consulting and its employees to coordinate treatment planning and care.

The student or legal guardian (if under 18) has the right to revoke this authorization at any time and must do so in writing. In case that the authorization is not revoked it will expire in 6 months from date of signing. Treatment is not conditional upon this authorization of release. Information disclosed shall not be redisclosed except where required by law or with explicit release and authorization.

Name of Educational Consultant *(if applicable)*:

Company Name _____
Phone _____ Fax _____
Email _____
Dates of Service _____

Name of Person *(required)* _____
Company Name *(if applicable)* _____
Relationship to Student _____
Phone _____ Fax _____
Email _____
Dates of Service _____

Name of Person *(required)* _____
Company Name *(if applicable)* _____
Relationship to Student _____
Phone _____ Fax _____
Email _____
Dates of Service _____

Name of Person *(required)* _____
Company Name *(if applicable)* _____
Relationship to Student _____
Phone _____ Fax _____
Email _____
Dates of Service _____

Name of Person *(required)* _____
Company Name *(if applicable)* _____
Relationship to Student _____
Phone _____ Fax _____
Email _____
Dates of Service _____

Name of Person *(required)* _____
Company Name *(if applicable)* _____
Relationship to Student _____
Phone _____ Fax _____
Email _____
Dates of Service _____

Signature of Parent/Legal Guardian _____ Date _____

Signature of Parent/Legal Guardian _____ Date _____



CONTACT INFORMATION

Student Name _____ Date of Birth _____

Age _____ Last Grade Completed _____

Allergies _____

Critical Medical Conditions _____

Parent Name _____ Relationship to Student _____

Primary Phone _____ Primary Email _____

Address _____

Parent Name _____ Relationship to Student _____

Primary Phone _____ Primary Email _____

Address _____

Parent Name _____ Relationship to Student _____

Primary Phone _____ Primary Email _____

Address _____

Parent Name _____ Relationship to Student _____

Primary Phone _____ Primary Email _____

Address _____

