NEWHOPE ACADEMY
3250 N. Arlington Heights Road
Arlington Heights, IL 60004
p 847.588.0463
f 847.588.0374
NHAforms@nhaweb.com

RELEASE OF INFORMATION

Student Name: _____ **Date of Birth:** _____
Last *First (Legal)*

Release Expiration: _____
(Typically two years from date of signing.)

Address: _____

_____

Our signature(s) below authorize, and request, the free exchange and release of the following protected oral and/or written school records, mental health, and health information regarding the above-named student/recipient:

☐ **All information, no restrictions**

☐ Admission/Discharge Summary
☐ Psychiatric Evaluation/ Medication Records
☐ Psychological Testing
☐ Education - IEP/School Assessments
☐ Verbal/Email Communication
☐ Other: _____

This information is to be released from/to NewHope Academy, 3250 N. Arlington Heights Road, Arlington Heights, IL 60004, and the following:

Name: _____

Title, if applicable:
(Psychiatrist, Therapist, Tutor, etc.) _____

Address: _____

Phone: _____

Fax: _____

Email: _____

The purpose of this release is for educational decision making and treatment planning. The undersigned acknowledges refusal to sign will result in the information not being released. The undersigned intends that a photocopy, facsimile, or digital copy of this form and any electronic signature will carry the same legal force and effect as the original. The undersigned further acknowledges that he/she has the right to revoke this consent in writing at any time but cannot do anything about records previously disclosed in reliance on this consent, and to inspect, copy, or challenge the contents of the records being requested prior to release. Knowing this, the undersigned intends to authorize the release of the designated records. Redisclosures of third-party files are not allowed unless specifically authorized. I understand that this authorization extends to all of the records/information designated above which may include treatment for physical and mental illness, alcohol/drug abuse, sexually transmitted disease, HIV/AIDS test results or diagnoses. I/we hereby release NewHope Academy from all legal responsibilities or liability that may arise from the use, disclosure or redisclosure of medical or other records and other health information in reliance on this authorization. The undersigned affirms that he/she is the authorized representative/ parent/guardian of the above-named Student and that his/her identification and proof of authority is true and correct, and that he/she has the authority to consent to the disclosure of information pursuant to this release. ***Note:*** *If any requested records contain information regarding alcohol or drug abuse treatment, these records are protected by Federal confidentiality rules. These rules prohibit further disclosure of this information unless further use or disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by Federal rules. A general authorization for the use or release of medical or other information is insufficient for this purpose. Federal rules restrict use of the information for criminal investigation or prosecution of any alcohol or drug abuse patient.*

_____	_____	
DATE	**STUDENT/RECIPIENT SIGNATURE - AGE 12 OR OVER**	
_____	_____	_____
DATE	**WITNESS TO STUDENT/RECIPIENT SIGNATURE**	**PRINTED NAME**
_____	_____	_____
DATE	**PARENT/GUARDIAN/AUTHORIZED AGENT**	**PRINTED NAME**
_____	_____	_____
DATE	**WITNESS TO PARENT/GUARDIAN/AUTHORIZED AGENT SIGNATURE**	**PRINTED NAME**