



AUTHORIZATION TO RELEASE INFORMATION and/or RECORDS:

STUDENT/PATIENT INFORMATION:

Name (Print)

DOB

INFORMATION TO BE RELEASED FROM:

Name of School, Facility or Provider

Address

City

State

Zip

Fax: _____ Telephone: _____

INFORMATION TO BE SENT TO:

Academy of Whole Learning

Admissions Office

3500 Williston Rd.

Minnetonka, MN 55345

Fax: 952-737-6901 Office: 952-737-6900

INFORMATION TO BE RELEASED:

- School Transcripts/Records
- Speech/Language Evaluation
- Immunization Records
- Physical Therapy Evaluation

- Individual Education Plan (I.E.P.)
- Occupational Therapy Evaluation
- Physical Examination

- Educational Assessments
- Treatment/Discharge Summary
- Neuropsychological Evaluation
(Psychiatric Evaluation, Psychological Evaluation, Psychosocial Evaluation)

PURPOSE FOR WHICH THE DISCLOSURE IS BEING MADE:

Educational/School Purposes Updated Records Other: _____

STUDENT/PATIENT AUTHORIZATION:

I hereby authorize you to release my child's requested records or documents to Academy of Whole Learning. I understand that an offer of admission cannot be made until all necessary records and documents have been received. I understand that my records may contain personal information and may include individually identifiable health information and will remain confidential.

MY RIGHTS:

I understand that, upon my request, I am entitled to a signed copy of this authorization form and the records to be disclosed. Unless sooner terminated in writing, this release shall remain effective for 1 year from the date signed below. A copy of this release shall be as sufficient to authorize release of information identified above as the original signed by me.

Name: _____ Signature: _____ Date: _____
(Parent/Guardian) (Parent/Guardian)

Academy of Whole Learning, 3500 Williston Rd., Minnetonka, MN 55345

(Fax): 952-737-6901