ST. FRANCIS HIGH SCHOOL
COLLEGE PREPARATORY

AUTHORIZATION FOR RELEASE OF INFORMATION

Student Name: _____ DOB: _____

- **I GIVE MY PERMISSION FOR:**

_____
(Doctor, Hospital, Therapist or Program)

_____
(Address)

_____
(Address)

- **TO RELEASE INFORMATION TO *OR* FROM THIS/THESE AUTHORIZED PERSON(S) AT ST. FRANCIS HIGH SCHOOL:**

_____
Person(s) and Extension(s)

- **SPECIFIC INFORMATION TO BE DISCLOSED:**

____	Initial Evaluation	____	Social History
____	Psychological Testing	____	Treatment Summary
____	Medical Evaluation/Tests	____	Observations/Recommendations
____	Educational Information	____	Clinical Impression
____	Other Pertinent Information	____	All of the Above
____	Other _____		

- **FOR THE PURPOSE OF:**

____ Ongoing Treatment Services
____ Consult with Therapist
____ Psychological Evaluation
____ Psychiatric Consultation
____ All of the Above
____ Other _____

I understand the reasons for the release of this information and have been informed of the benefits or disadvantages associated with such release. It is understood that the person authorizing release of this information has the right to inspect and copy information to be disclosed and that this information will not be redisclosed without proper authorization.

_____	_____	_____
(Date)	(Patient Signature)	Parent(s)/Guardian(s) Signature(s)

2130 W. Roosevelt Road ▪ Wheaton, Illinois 60187-6029
(630) 668-5800 ▪ Fax (630) 668-5893 ▪ www.sfhsnet.org