NORWELL HIGH SCHOOL
1100 E US 224
OSSIAN, IN 46777
260-543-2213

RELEASE OF INFORMATION

Student's Name _____ Date of Birth _____

Student Lives with _____
(Name) (Relationship)

Address _____
(Street) (City, Sate, Zip Code)

School where presently enrolled _____ Current Grade _____

For the purposes of providing the most appropriate instruction and assistance in school, I do hereby give permission for a mutual exchange of academic information, psychoeducation evaluations and/or medical evaluations for the above mentioned student, between NORWELL HIGH SCHOOL and the following:

_____
(Hospital, School Corporation/School, Agency, Behavioral Health)

_____
(Physician's name, Principal, Contact Person/People)

_____
(Address)

_____
(Phone Number)

_____
(Signature of person giving consent) (Relationship)

Date Signed: _____ This consent to release information is valid for 180 days from date of signature unless revoked earlier by the client.

For Behavioral Health/Mental Health, please specify and initial:

____Psychiatric Evaluation ___ Discharge Summary ___ Safety Plan

____Therapy/Social Worker Documentation

Additional Comments or Instructions:

_____

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