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:
Franklin Academy
Admissions Office
1001 Boone Ave. N.
Minneapolis, MN 55427
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 Franklin Academy. 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)