NEWHOPE ACADEMY
3250 N. Arlington Heights Rd., 200 Wing ● Arlington Heights, IL 60004 ● 847.588.0463 ● Fax 847.588.0464 ● www.nhaweb.com

RELEASE OF INFORMATION 2018-19

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
- ☐ Physician Progress Notes
- ☐ Therapist/Social Services Progress Notes
- ☐ Treatment Plans
- ☐ Psychological Testing
- ☐ Education - IEP/School Assessments
- ☐ Medication Records
- ☐ Verbal Communication – No Restrictions
- ☐ Verbal Communication – Restrictions:_____
  _____
- ☐ Other: _____

This information is to be released from/to NewHope Academy, 3250 N. Arlington Heights Rd., Suite 200, Arlington Heights, IL 60004, and the following:

Name: _____

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

Address: _____

Phone: _____

Fax: _____

This information is intended for use in educational decision making, treatment planning, and/or preparation for court proceedings. 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 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, 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 pursuant to 105 ILCS 10/6(a)(8) of the Illinois School Student Records Act. **This consent covers the full contents of the temporary and permanent files as these are defined in the Illinois School Student Records Act, and data reported by the above-named student's school district to the Illinois State Board of Education's data systems, including, and without limitation, the IWAS/SIS system**. 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.

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