Release of Information

Counselors Sarah Taffe (612-798-2654) **and Jake Schuman** (612-798-2638)
Academy of Holy Angels
6600 Nicollet Ave. S.
Richfield, MN 55423
Fax: 612-798-2610

_____ _____
(Name of Client/Student) (Birth date)

I _____ (name of minor's parent who is authorizing the school's release and/or exchange of information) hereby authorize the ***Academy of Holy Angels*** to release of the following information:

_____Comprehensive school records including academic, behavioral, health and attendance records

OR

_____ Standardized testing information
_____ Academic information
_____ Attendance records
_____ Social/Emotional well-being

Name of facility/agency or psychological practitioner with whom the information is to be exchanged:
_____

Address (if known)_____

_____

Fax # _____ Phone # _____

I also allow the psychological practitioner agency named above to exchange the following information with the counselor(s) from the Academy of Holy Angels.

_____All information needed for continuity of care
_____Psychological testing results
_____Other _____

_____ _____
(Signature of Parent) (Date)

_____ _____
(Signature of Student, if applicable) (Date)

_____ _____
(Witness Signature) (Date)