



**AUTHORIZATION TO OBTAIN AND RELEASE
STUDENT PHYSICAL AND MENTAL HEALTH INFORMATION**

Name of Student: _____ Date of Birth: _____

In my capacity as the parent or legal guardian of the above-named student (the “Student”), I hereby authorize Blair Academy’s Director of Counseling and School Counselors (the “Academy Counseling Team”) to obtain the Student’s personal health information, including, but not limited to, copies of records pertaining to the Student’s medical and psychological treatment, evaluation, and/or care, from:

Institution/Practice/Provider: _____

Address: _____

Telephone Number: _____ Email: _____

I further authorize the Academy Counseling Team to confer (telephonically, in person, electronically, or otherwise) concerning the Student’s treatment, evaluation, and/or care with any professional providing the Student’s personal health information at the above-named institution/practice/provider. I agree and understand that this authorization allows for the institution’s/practice’s/provider’s disclosure to the Academy Counseling Team the Student’s personal health information. The Student’s personal health information includes, but is not limited to, a summary of records, social history, treatment plans, consultation reports, medical assessments, lab tests, and psychological and academic test results.

In addition, this authorization allows the Academy Counseling Team to disclose to the above-named institution/practice/provider information about the Student’s enrollment in and attendance at Blair Academy, including educational and counseling information, as determined appropriate by the Academy Counseling Team, for purposes of supporting the Student’s outside treatment and/or experience at Blair Academy.

I understand that this authorization is subject to revocation at any time upon my written request, except to the extent that action has been taken in reliance on this authorization; otherwise, this authorization will remain in effect while the Student is enrolled in Blair Academy.

By signing below, I, the undersigned, acknowledge and authorize the disclosure of the Student’s records and information as specified. While both a parent/guardian and the Student are requested to sign, a single signature, either from one parent/guardian or the Student if 16 years of age or older, may be sufficient to authorize this disclosure.

Signature of Parent/Guardian: _____ **Date:** _____

Print Full Name of Parent/Guardian: _____

Signature of Student: _____ **Date:** _____