TURNING POINTE
AUTISM FOUNDATION

AUTHORIZATION TO RELEASE INFORMATION

Student Name:	**Date of Birth:**
Parent/Guardian Name (If Applicable):	

I authorize the person or agency listed below to release protected health information, educational information and/or otherwise confidential information.

PERSON/AGENCY RELEASING RECORDS		
Name/Organization: Turning Pointe Autism Foundation		
Address: 1500 W. Ogden Avenue		
City: Naperville	**State:** Illinois	**Zip Code:** 60540
Phone: (630) 570-7948	**Fax:** (630) 615-6050	

RECORDS/INFORMATION MAY BE GIVEN TO:

PERSON/AGENCY RECEIVING RECORDS		
Name/Organization:		
Address:		
City:	**State:**	**Zip:**
Phone:	**Fax:**	
Email:		

☐ Check here if authorization is given for the parties listed above to mutually exchange the information indicated below.

I understand that signing this authorization is voluntary and may be revoked at any time by providing written notice to Turning Pointe Autism Foundation and will otherwise expire 12 months (1 year) after my signature date below. The withdrawal of this authorization does not affect any information disclosed prior to receiving written notice.

TYPES OF INFORMATION TO BE RELEASED	
☐ Educational Records	☐ Medical Records
☐ Psychological Reports	☐ Behavioral Reports
☐ Social History	☐ Consultation Regarding Student
☐ Correspondence	☐ Other:
Please list any restrictions:	

PURPOSE OF RELEASE OF REQUESTED INFORMATION (CHECK ALL THAT APPLY)	
☐ Educational Evaluation/Planning	☐ Health Assessment/Medical Planning
☐ Ongoing Communication/Consultation	☐ Other:

_____ _____

Parent/Guardian Signature Date