Authorization for Release of Information

I, ____ the legal parent or guardian (Sponsor) (or the Student, if 18 or older) of ____________________________________ (Student), herby authorize Greenbrier Academy ("Greenbrier Academy") and the below named person/organization to exchange the Student's (set forth above) medical and clinical information relating to dates of treatment, medical, psychological, social, psychiatric, and/or substance abuse diagnoses, treatments, prognosis, counseling, school records, and/or therapy herein contained in the patient's medical records.

Please release the following information for the approximate Date(s) of Service:

FACILITY	
STREET ADDRESS	
CITY	
STATE, ZIP CODE	
PHONE NUMBER	

- ☐ Discharge Summary
- ☐ Physician Orders
- ☐ Physician Progress Notes
- ☐ History and Physical Examination
- ☐ Laboratory/Radiological Reports
- ☐ Psychosocial History
- ☐ Psychiatric Evaluation
- ☐ Consultation Reports
- ☐ Clinical/Nursing Staff Progress Notes
- ☐ Medication Administration Records

Psychological Testing Other ____________________________________

MAILING ADDRESS: Greenbrier Academy, 158 Academy Lane, Pence Springs, WV 24962 Attn: Admissions Department

This authorization is valid one (1) year from the date signed. This consent is subject to revocation in writing by the undersigned at any time, except to the extent that action has been taken in reliance thereon.

Sponsor Signature (Father/Guardian)

____

Name: ________________________________

Date: ________________________________

Sponsor Signature (Mother/Guardian)

____

Name: ________________________________

Date: ________________________________