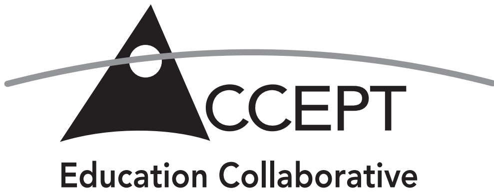

220 North Main Street, Suite 201, Natick, MA 01760
508.653.6776 • 508.653.0878 Fax • **accept.org**

Release of Information & Records

Name of Student:___________________________

Date of Birth________________

By signing below, I hereby request and authorize the following persons or organizations to exchange all pertinent information and/or records regarding my child with ACCEPT Education Collaborative staff.

Name of person and position or agency	Phone Number and Address
1.	
2.	
3.	
4.	
5.	

Note: The confidentiality of Medical and Psychiatric records is required under Massachusetts General Statues. By law, no information may be transferred to another party without written consent or other authorization of the parent/guardian. The patient or parent/guardian has the right to revoke the above agreement at any time. This request expires one year from this date.

Signature of parent/guardian:______________________________________

Signature of student (required if over 18):_____________________________

Date:_______________

UNLOCKING POTENTIAL • ACHIEVING SUCCESS