

RISE Learning Center

5391 Shelby Street, Indianapolis, IN 46227 (317) 789-1621
 Dr. Scott Carson - Director Fax (317) 780-4268

Release and Request for Mutual Disclosures

Student _____ DOB _____ Grade _____ District _____
 Student Address _____

I, _____, in reference to the above-mentioned student, hereby request and authorize RISE Learning Center/Southside Special Services of Marion County to

Release information TO and/or Obtain the following information FROM

GP/Pediatrician:	Provider's Name:	Phone:
	Office/Group Name:	
Specialist:	Provider's Name:	Phone:
Mental Health:	Provider's Name:	Phone:
PT/OT:	Provider's Name:	Phone:
Other:	Provider's Name:	Phone:

This request and authorization applies to:			<input type="checkbox"/> All Stated Below
Diagnosis and Evaluation	Educational Records	Discharge Termination Summary	
Psychological Testing	PT/OT	Speech	
Feeding-Swallow Study	Other pertinent information:		

PLEASE NOTE: If the person or entity receiving this information is not a health care provider or school covered by federal privacy regulations, the information described above may be disclosed to other individuals or institutions and no longer protected by these regulations. You may refuse to sign this authorization. You may inspect or copy the special education records to be used or disclosed under this authorization. You may revoke this authorization in writing at any time by sending written notification to RISE Learning Center/Southside Special Services of Marion County at 5391 S. Shelby Street, Indianapolis, IN 46227, or by e-mail with Verbal notification to RISE/Southside Special Services. Your notice will not apply to actions taken by the requesting person/s or entity prior to the date we receive your request to revoke authorization.

Release effective from _____ to _____

X _____ **X** _____
 Parent or Guardian Witness

Date: _____ Date: _____