



Consent to Release Information

This agreement provides an authorization for use and disclosure of protected information. Complete a separate agreement for each provider.

Authorization: I authorize _____ (School) to use and disclose information described below to **Alexander W. Merrill & Faculty of Alliance Tutoring LLC**.

Contact Information of Educational provider/consultant/institution:

Phone: _____

Email: _____

Effective Period: This authorization for release of information covers the period from:

- ☐ Dates:
- ☐ All past, present, and future periods

Extent of Authorization:

- ☐ I authorize the release of the complete education record
- ☐ I authorize the release of the complete health record except for:
 - ☐ mental healthcare
 - ☐ communicable diseases (including HIV/AIDS)
 - ☐ treatment of alcohol and drug abuse
 - ☐ other _____

Usage: This information may be used by the person I authorize to receive this information for academic tutoring, billing or claims payment, or any other reason I may direct.

Rights:

1. I have the right to revoke this authorization, in writing, at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance of my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

2. I understand that my tutoring, payment, enrollment, or eligibility for benefits will not be conditioned on whether I sign this Consent to Release Information.

Name of Student: _____

Student Date of Birth: _____

Student Signature: _____

Date: _____

If Student is a Minor:

Parent Signature: _____

Date: _____

Parent Name: _____