NEW HORIZONS ACADEMY
6701 W. Charleston Blvd.
Las Vegas, Nevada 89146
(702) 876-1181
Fax: (702) 365-7807

AUTHORIZATION TO RELEASE CONFIDENTIAL INFORMATION

I. STUDENT'S NAME: _____BIRTHDATE_____

I authorize release of all of the following records: Psychoeducation Evaluations, Transcripts, Report Cards, Medical, and Health Reports. ADHD Evaluations, Disciplinary records, Behavioral records or/checklists.

I request that the information be kept confidential; used for professional reasons only and not be released to another individual or organization unless authorized by me. I understand that I have the right to inspect or receive a copy of the school records that are released.

Reasons for release: In order to plan an individualized education program for my child.

Signed _____ Date_____
☐Parent or ☐Guardian

Requested by: _____ ☐ School Official ☐ Psychologist ☐ Other: _____

II. Information to be released from:

_____
(Name of School, Private Evaluator, Physician, other)

_____
Address

_____
City State Zip

_____
Fax

III. Information to be released to:

New Horizons Academy
School

6701 W. Charleston Blvd.
Address

Las Vegas, NV 89146
City State Zip

(702) 365-7807
Fax

USE THIS FORM WHEN:

1. Releasing information to other organizations.
2. Obtaining information from other organizations.
3. Releasing information to parents, or adult age student (18 years or older).