

AUTHORIZATION TO RELEASE AND RECEIVE CONFIDENTIAL INFORMATION

Identification of Parties:

Records Subject: _____ Date of Birth: _____

Name of Records Requester: Hamilton & Associates Educational Consultants, LLC

Name(s) of Provider(s): _____

Explanation: This authorization to release and receive confidential information is to comply with the terms of the appropriate governing California Codes, including California Civil Code Sections 56 through 56.16.

Authorization: The undersigned, as the parent or legal guardian of Records Subject, hereby authorizes the Provider(s) named above to furnish to the Records Requester, or their agent, designee or representative, the following records regarding the Records Subject: Records of medical history, services, treatment and diagnoses; records of academic history, awards, and review. These records are to be provided to the Records Requester for the following limited purpose: To allow Records Requester to fully evaluate the Records Subject, to recommend appropriate schools/programs to which Records Subject should apply for admission, and to assist Records Subject in making complete applications.

Duration: This authorization shall become effective immediately and shall remain in effect as long as necessary for the Records Requester to fulfill the purpose set forth above, but in no event for more than one year from the date of this Authorization.

Restrictions: I understand that the same restrictions for receipt and release of confidential information apply to Records Requester as to Provider, and that no further authorization is made that is specifically indicated in this form.

Additional Copy: I understand that a photocopy of this authorization is to be considered as valid as the original. I further understand that I have a right to receive a copy of this authorization upon my request.

Signature:

Date

Parent or Legal Guardian