KEYSTONE EDUCATIONAL MANAGEMENT SERVICES
1101 E. Gregory St.
Des Plaines, Illinois, 60016-1231
Phone: 847/826-0584 Fax:847/803-8669
CEO: Michael E. Schack MA, MBA

AUTHORIZATION FOR THE RELEASE OF INFORMATION

Student Name: ____

Date of Birth: ______________________ Home School: _________________________

I hereby authorize ____
(Name of person or District)
to send copies of my case study evaluation and educational records to Joseph Academy on order to plan a program for my educational needs.

The following information can be sent to Joseph Academy:

EDUCATIONAL TESTS	________	PSYCHOLOGICAL TESTING	________
PHYSICAL EXAM	________	PSYCHIACTRIC EXAM	________
SOCIAL HISTORY	________	DISCHARGE SUMMARY	________
IEP REPORT	________	SCHOOL TRANSCRIPTS	________
MDC	________	CONTRACT	________

I give my consent freely and voluntarily. I realize that services cannot be provided without sufficient information.

Student Signature: ___________________________________ Date: _______________

Parent Signature: _____________________________________ Date: _______________

Witness Signature: ____________________________________ Date: _______________