

# This first page provides instructions only.

1) Write in your school or school district name rather than the teacher assigned to your student. This allows us to speak to any involved in the care of your child employed or contracted with the school district

Also, include all other current caregivers you wish us to collaborate with; many find it useful to include the students' private service providers.

When completed in this manner we revisit this document annually only.

2) Check all boxes which may apply. Typically this includes those in bold font.

3) If you can participate then, place **two** marks here. One mark next to *each* arrow ➡.

If you are not participating, then write **NA** next to the first arrow and check the top box by the second arrow.

In 2024 Pinnacle Education opens a tutor training clinic in which we hope our students can participate as examples. This means a student's lesson may be recorded and a clip may be shared to help educate others in teaching methods. **You are not required to participate and we are happy to honor your wishes as indicated on this form.**

**Pinnacle EDUCATION SERVICES** Sarah M. Fish Academic Intervention Specialist

### Authorization for the Release or Exchange of Information

This form, when completed and signed by you, authorizes Sarah M. Fish, to exchange (obtain, release or share) protected health and educational information regarding you/your child with the person or organization designated below.

**1) Organization/Person** (school district, doctor, therapist, psychologist, occupational therapist, speech and language therapist other service providers)  
Magical School District, Jane Smith SLP, Fabulous Therapist

**This Authorization pertains to specific clinical information regarding:**  
Name (student): Bob Jones DOB: 12/03/2011  
Address: 000 100th Street City, State, Zip  
Parent/Guardian Name (if applicable): Robert Jones  
Phone of parent/guardian: 000-000-0000

I, Robert Jones (parent name), authorize my/my child's Academic Intervention Specialist, Sarah M. Fish, to exchange (obtain, release or share) the following information:  
(generally, just the bold font records)

<input checked="" type="checkbox"/> Educational Records	<input type="checkbox"/> Mental Health Treatment Plan(s)	<input type="checkbox"/> Medical History
<input checked="" type="checkbox"/> Assessment Data/Results	<input type="checkbox"/> Mental Health Progress Notes	<input type="checkbox"/> Psychiatric Evaluation
<input type="checkbox"/> Court/Agency Documents	<input checked="" type="checkbox"/> Psychological/Neuropsychological Reports	<input type="checkbox"/> Mental Status Exam
		<input type="checkbox"/> Health Treatment Plan

**CLIENT/GUARDIAN SIGNATURE:** Robert Jones **DATE:** 07/06/2023

### Authorization for the Release of Videos and Photos

I hereby grant permission without time limit to the rights of the above person's image to be used in photographic, audio or video recording form for the following purposes: • conference presentations • educational presentations or courses • informational presentations • on-line educational courses • educational videos • instructional training. These recordings may be displayed

**3) Choose one**  On the internet or in public settings to help educate and train others  
 For tutor training only (not be displayed publicly)

**Choose one**  I do not give permission for the client's photograph, audio or video recordings to be used.  
 I do give permission for the client's photograph, audio or video recordings to be used.

By signing this form I acknowledge that I have completely read and fully understand the above release and agree to be bound thereby. If I mark I do give permission, then I hereby release any and all claims against any person or organization utilizing this material.

**CLIENT/GUARDIAN SIGNATURE:** Robert Jones **DATE:** 07/06/2023

SarahF@PinnacleEducationServices.com 360.825.3131 Pinnacle Education Services

**This document is valid only when a hand (or finger) signature has been used; it is not valid if you type in a signature. Ways to remotely complete this document include:**

- digital signature using your iphone photo app (screenshot the PDF and draw the signature)
- print, wet-ink sign and send a cell photo of the signed paper
- digital signature app like DocUsign
- open as a PDF in another piece of software or app (Adobe, Kami, etc)

-----The following page is to be signed and returned prior to service commencement.-----

### Authorization for the Release or Exchange of Information

This form, when completed and signed by you, authorizes all agents of Pinnacle Education Services LLC, to exchange (obtain, release or share) protected health and educational information regarding you/your child with the person or organization designated below.

**Organization/Person** school district, doctor, therapist, psychologist, occupational therapist, speech and language therapist other service providers, etc.  
Name all below that you would like us to consult with. All district personnel can be covered by naming the district rather than each person's name.

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### This Authorization pertains to specific clinical information regarding:

Name (student): \_\_\_\_\_ DOB: \_\_\_\_\_

Parent/Guardian Name: \_\_\_\_\_

Address of student: \_\_\_\_\_

Phone of parent/guardian: \_\_\_\_\_

I, \_\_\_\_\_, authorize all agents of Pinnacle Education Services LLC.  
parent/guardian name

to exchange (obtain, release or share) the following information:

generally, just the bold font records

Educational Records  
 Assessment Data/Results  
 Court/Agency Documents

Mental Health Treatment Plan(s)  
 Mental Health Progress Notes  
 Psychological/Neuropsychological Reports

Psychiatric Evaluation  
 Mental Status Exam  
 Health Treatment Plan

**CLIENT/GUARDIAN SIGNATURE:**

**DATE:**

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**CLIENT/GUARDIAN SIGNATURE:**

**DATE:**