AUTHORIZATION FOR RELEASE OF INFORMATION

Date_____ Student's Name _____

DOB _____ Age_____

Address _____

_____

This Individual Authorizes: _____
_____
_____
_____

To Disclose To: _____
_____
_____
_____

The following information (i.e., records, describe nature of information from any physician, hospital, school, clinic, agency or institution having medical, psychological, school or social records): _____

_____

I understand that my records are protected under the Federal Confidentiality Regulations and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I also understand that I may revoke this consent at any time except to the extent that action has been taken in reliance on it (i.e. probation, parole, etc.).

List any special condition or qualification of this consent form:_____

_____

_____ _____
Parent/Guardian or Authorized Representative Signature — Relationship

_____ _____
School Official Signature — Title