Student's Name:____

Address:____**Phone:**_________________________

DOB:__________________________**Grade:**______________**SSN:**__________________________

CONSENT & AUTHORIZATION TO RELEASE INFORMATION

I, ___________________________________on this _______day of ___________200__, hereby request
(Parent/Guardian/Student)

and authorize_________________________________of____

to release the information checked below to: ____
(Name of Person/Organization)

____
(Address)

SPECIFIC INFORMATION TO BE RELEASED:

____Cumulative Academic Record	____Physical	____Psychosocial History
____Consultation Reports	____Physician Orders	____Other (Specify)____________
____Diagnosis	____Progress Notes	__________________________
____Educational Evaluations	____Psychiatric Eval.	__________________________
____History	____Psychological Tests	__________________________

REASON FOR RELEASE OF INFORMATION:

____Educational/classroom placement	____Provide mental health intervention services
____Develop academic/or psychosocial support plan	____Provide recommendations regarding MH status
____Conduct psychiatric evaluation	____Other:_________________________________

I understand that I may revoke this consent at anytime, and , in any event, it shall expire 90 days from date unless sooner revoked, but not retroactive to the release of information made in good faith/and further, that upon fulfillment of the above stated purpose, this consent will automatically expire without my express revocation.

TO THE PARTY RECEIVING THIS INFORMATION: This information has been disclosed to you from the records, the confidentiality of which is protected by federal law. Federal regulations (42 CFR Part 2) prohibit you from making any further disclosure of it without the specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations. A general authorization for the release of medical or other information is not sufficient for this purpose.

Signed:____Date:________________________

Witness: ____Date: ________________________