AUTHORIZATION TO OBTAIN AND RELEASE
CONFIDENTIAL INFORMATION

I, ________________________________(parent/guardian name), give permission to Denver Jewish Day School's Counseling Department, to provide and receive the following information on:

		Denver Jewish Day School
(Name of Student)	(D.O.B.)	(Name of School)

Attn: ____

Address: ____

Fax: ______________________________ Phone: ________________________________

Information and records requested/to be disclosed are: counseling issues related to school success, and other information as noted:

____

Purpose(s) or need for which information is to be used:______________________________

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If the person for whom records and information are requested is under 18 years of age, the release must be approved by the parent or guardian. If the person is 18 years of age or older, the release must be approved by that individual.

____________________________________ ____________________

Signature (Parent/Guardian) or as noted above Date

____

Address