



**AUTHORIZATION TO RELEASE/EXCHANGE CONFIDENTIAL INFORMATION**

This form cannot be used for the re-release of confidential information provided to Delta High School by other individuals or agencies. Such requests should be referred to the original individual or agency.

I \_\_\_\_\_ authorize Delta High School to:

\_\_\_\_\_ release to:

\_\_\_\_\_ obtain from:

\_\_\_\_\_ exchange with:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

the following information pertaining to myself/my student:

\_\_\_\_\_ treatment summary

\_\_\_\_\_ history/intake

\_\_\_\_\_ diagnosis

\_\_\_\_\_ psychological test results

\_\_\_\_\_ psychiatric evaluation/medication history

\_\_\_\_\_ dates of treatment attendance

\_\_\_\_\_ other (specify) \_\_\_\_\_

for the purpose of:

\_\_\_\_\_ evaluation/assessment and/or coordinating treatment efforts

\_\_\_\_\_ other (specify) \_\_\_\_\_

This consent will automatically expire one (1) year after the date of my signature as it appears below, or on the following earlier date, condition, or event \_\_\_\_\_

\_\_\_\_\_.

I understand I have the right to refuse to sign this form, and that I may revoke my consent at any time (except to the extent that the information has already been released).

\_\_\_\_\_  
Signature of Parent/Guardian Date AND/OR

\_\_\_\_\_  
Signature of Student Date of Birth Date