SCOTT COUNTY SCHOOLS
2168 Frankfort Rd
Georgetown, KY 40324
502.863.3663

AUTHORIZATION TO RELEASE AND CONSENT TO EXCHANGE INFORMATION

I/We, _____ ,

I am/are the (Check one):
☐ Parent(s) ☐ Legal Guardian ☐ Agent of the State , for

_____ _____
(Name/Student) *(Date of Birth)*

My/our mailing address and phone number:

AUTHORIZATION

I authorize the following agencies and individuals to exchange confidential information pertaining to the above named child/student:

(Agency Name, Title, and name of Specific Contact Person or Designee)
AND

(Agency Name, Title, and name of Specific Contact Person or Designee)

Additional agencies who may exchange information are listed on the back: ☐ Yes ■ No

SOURCE AND TYPE OF INFORMATION

My consent to the exchange of information applies to the following sources of information and shall be utilized for the purposes of school based decision making and/or service coordination and treatment planning:

YES	NO		YES	NO	
☐	☐	Assessment Information	☐	☐	Medical Diagnoses
☐	☐	Psychiatric Records	☐	☐	Medical Records
☐	☐	Educational Records	☐	☐	Criminal Justice Records
☐	☐	Psychological Records	☐	☐	Services Information

Other information that may be released or exchanged: _____

The form of information that may be exchanged: ■ Verbal ■ Written ■ Computerized

ACKNOWLEDGEMENT

I have read and understand this authorization and consent will remain effective until I revoke it by notifying the agencies in writing. This will stop the exchange of information authorized by this document.

Print Name: _____ Signature: _____ Date: _____

Print Name: _____ Signature: _____ Date: _____