Consent for Coordinating Services and Records Release
Putnam County ESC

Student Name: _____ DOB: _____ Age:_____

District of Residence: _____ District of Service: _____

All records released and coordinated services are for the sole purpose to benefit the student's well-being.

Specific Person/Agency

_____ _____
Person/ Agency/Hospital/Physician Attention To/Name (if business)

_____ _____
Address Phone Number

Multiple Person(s)/Agency

___ Putnam County Job & Family Services
___ Pathways or other Mental Health Counselor
___ Putnam County Court(s)
___ Putnam County Board of DD
___ Putnam County Health Department
___ Social Security Administration
___ Adult or Juvenile Probation
___ Opportunities for Ohioans with Disabilities (OOD)
___ Hospital/Doctor Office (specify below)
_____
___ Family & Children First Council/WRAP
___ Residential Placement Facility/Coordinator
___ Other: _____
___ Other: _____

My signature below indicates that I authorize sharing the following information:

-Identifying information, privileged health and medical information, social history, treatment/service history, psychological evaluation, IEP's, ETR's, transition plans, vocational assessments, grades and attendance, performance history and other personal information held by any of the agency providers, regarding those personas named on this case.

_____ _____ _____
Signature of Parent/Guardian (or student if age 18 or older) Relationship Date Signed

Date Consent for Agency Participation <u>expires</u>: __until revoked_____

This Consent for Agency Participation can be revoked at any time by signing this form. Use this box only if the Consent for Agency Participation is being revoked.

_____ _____
Signature of Parent/Guardian (or student if age 18 or older) Date Signed

Updated 8/7/24