

CONSENT FOR RELEASE OF INFORMATION

I hereby authorize _____ to release and/or obtain the following information regarding _____ with the individual(s)/organization(s) listed below.

Information may be released to/from:

Name: _____

Phone Number: _____

Email: _____

I am authorizing the release of the information/reports specified below:

____ Clinical Information (e.g. evaluations, progress reports, discharge summaries, treatment plans, etc)

____ Medical Information (e.g. nursing reports, medical history/evaluation, etc)

____ Academic Information (e.g. academic progress, academic grades/records, etc)

____ Other, please specify: _____

This information may be in the form of:

____ Written Records ____ Verbal Information.

This information is requested for the purposes of:

____ Treatment Coordination ____ Evaluation ____ Case Management

____ Other, please specify: _____

I understand that this consent for the release of information will be in effect beginning _____ and will remain active for no more than 1 calendar year. I further understand that this consent may be revoked at any time by written request (or by verbal request if I am unable to provide a signature) unless already acted upon by Unionville-Chadds Ford School District.

This information is protected by confidentiality rules and school district policies. These rules prohibit any further disclosure of this information unless further disclosure is requested by the written consent of the person to whom it pertains or as otherwise permitted by law. Federal rules restrict any use of information regarding alcohol or drug abuse treatment.

I understand that I am consenting to release this confidential information to be used only in a professional manner by the person/organization to which this information is being forwarded.

Student Signature (*14+ years old preferred, not required*)

Date

Parent/Guardian Signature

Date