



GOSHEN COUNTY SCHOOL DISTRICT NO. 1

Release of Information (ROI) Authorization

Student Name: _____

Date of Birth: _____

School: _____

Parent/Guardian Name: _____

Private Counseling Provider/Agency: _____

Counselor Name: _____

Phone: _____ **Email:** _____

Section A: Release of Information (Required)

I authorize Goshen County School District No. 1 and the private counseling provider listed above to communicate and exchange information necessary to coordinate counseling services and support my student.

Information that may be exchanged includes:

- ☐ Attendance
- ☐ Academic Progress
- ☐ Behavioral Concerns
- ☐ Social/Emotional Functioning
- ☐ Recommendations Relevant to Student Success
- ☐ Scheduling and Coordination of Services
- ☐ Safety Concerns
- ☐ Other: _____

I understand this authorization is for the purpose of coordinating services that support my student's educational, social, emotional, and behavioral needs

Section B: Permission for Counseling Services During School Hours

I give permission for my student to participate in counseling sessions with the above-named private counseling provider during the school day.

I understand that:

- Sessions may require my student to miss portions of instructional time.
- The counselor must coordinate scheduling through the school counselor and/or front office staff.
- School space for counseling sessions is dependent upon availability.

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