RE: __________________________________________
D.O.B.: ________________________________

I, __________________________________________ hereby authorize
(Name of Student or Guardian)
______________________________
(School Personnel)

to obtain from/release to, and communicate with
______________________________
(Agency Name/Address/Phone Number)

regarding information from ____________________________ records, including:
(Name of Student)

_____ Treatment Summary

_____ Treatment Recommendations

_____ Diagnosis

_____ Discharge Summary

_____ Treatment/Aftercare Plan

_____ School records including school
Reports, standardized test data, behavioral information, Evaluation
Reports (ER), and Individual
Education Plans (IEP)

_____ Phone Contact

_____ Other ____________________________

for the purpose of ____________________________ .
This consent will begin the date of this authorization and will expire one year later, on _____________, unless
revoked by me in writing. I, the undersigned, hereby acknowledge that I have read this authorization prior to its
execution and fully understand the nature of this release. All information released will be handled confidentially in
compliance with the Family Educational Rights and Privacy Act (FERPA).

Signature of Student (If student is over 14 years of age)
________________________________________

Signature of Witness
________________________________________

Signature of Parent/Guardian
________________________________________

Date
________________________________________

I, __________________________________________, do not authorize
(Name of Student or Guardian)
(School Name/Address/Phone Number)

to obtain from/release to, and communicate with any
agency/physician/mental health personnel at this time regarding ______________________________.
(Name of Student)