ORLEANS CENTRAL SUPERVISORY UNION

130 Kinsey Road Barton, VT 05822

Albany * Barton * Brownington * Glover * Irasburg * Lake Region * Orleans

AUTHORIZATION FOR RELEASE AND/OR REQUEST FOR INFORMATION

Student_____ DOB_____

I, _____ give _____
(Parent/Guardian) (School/District)

staff permission to engage in verbal and/or written communication with and release/request information regarding my child and/or my child's records from:

_____

_____.
AGENCY (Name, Address, Phone/Fax Number)

The disclosure is to be used for the following purposes:

☐To support student's educational needs ☐To determine special education needs
☐Program evaluation ☐Medical and health needs
☐Mental health evaluation and/or treatment for a student, and referrals to school/other services
☐Other: (Specify) **_____**

Information released may include the following specific records:

☐Health/Medical Records ☐Psychological and/or Psychiatric Evaluations
☐Treatment Plans ☐Treatment/Discharge Summaries
☐Case/Progress/Therapy Records ☐Mental Health Information and Reports
☐Alcohol/Drug Information and Reports ☐Recommendations and Referrals
☐Diagnostic Evaluation/Examination Reports
☐Other: (Specifiy) **_____**

I acknowledge that all information I authorize to be released or requested will be held strictly confidential and cannot be released by the recipient without an additional written consent. I understand that authorization will expire one (1) year after the date signed. I further understand that I may withdraw my consent in writing at any time.

_____ _____
(Signature of Parent/Guardian/Student at Age of Majority) (Date)

***Complete one form for each provider**

Date Form Last Modified: September 6, 2018