SAMPLE CONSENT TO RELEASE INFORMATION

Child/Youth Name: _____ **Date of Birth:** _____

AS PARENT/GUARDIAN OF THE ABOVE CHILD, I HEREBY REQUEST THE RELEASE OF CONFIDENTIAL INFORMATION *(Including Educational Plans, Assessment Result, Medical Findings, Developmental, Health and Immunization History, Legal Proceedings and /or Relevant Data)* **TO THE FOLLOWING AGENCY:** ***(Name & address of your organization)***

For the purpose of exchanging information on the above child/youth in an effort to provide the most appropriate services to meet the needs of the child/youth.

(Complete separate form for every agency your organization is authorized to release information to.)

Name of Agency

_____

(Addresses, Phone Numbers if needed):

_____

_____

_____

I AUTHORIZE THE RELEASE OF CONFIDENTIAL INFORMATION TO BE GIVEN TO THE ORGANIZATION LISTED ABOVE. CONSENT WILL EXPIRE 12 MONTHS FROM DATE OF SIGNATURE.

_____

Youth/Family Signature ***Date***

_____

Address

_____

City, State, Zip

_____

Phone

IF YOU CHOOSE TO REVOKE THIS AUTHORIZATION TO RELEASE CONFIDENTIAL INFORMATION AT A FUTURE DATE, CONTACT THIS AGENCY SO YOU CAN MAKE ARRANGEMENTS TO SIGN AND DATE THE REVOCATION BELOW:

_____

Youth/Family Signature ***Date***