Cleveland School District

AUTHORITY TO RELEASE CONFIDENTIAL INFORMATION

Requesting Agency Information

CLEVELAND SCHOOL DISTRICT

Attention to:

Mandy Wilburn, RN, BSN, NCSN

305 Merritt Drive, Cleveland, MS 38732

Fax: 662-579-3090

I _____ hereby consent to :

(Parent/Guardian)

The exchange/release of information between _____ and Cleveland School District for the specific purpose of evaluation and placement in the Cleveland School District. Information obtained through this agreement will be kept confidential.

I specifically consent to the release of all medical/mental health information pertaining to :

Check all that apply:

_____ Evaluations/Diagnosis

_____ Medical/Psychiatric Records/Case Notes

_____ Prognosis and/or recommendation

_____ Treatment/Substance Abuse Planning (to include medications)

_____ Other

I understand that I may revoke this consent at any time except to the extent that the program or person which is to make the disclosure has already taken action. I further understand that this consent will expire upon _____ and cannot be renewed without my written consent.

(1 year from date)

_____

Parent/Guardian Signature Date

_____ _____

Witness Signature Date School Representative Date

_____

Client Identifying Data

_____ _____ _____

Name Date of Birth Social Security Number