Authority to Release Confidential Information
Cleveland School District
Health Services
305 Merritt Drive
Cleveland, MS 38732
662-843-3529 Office 662-579-3090 Fax

I _____ hereby consent to the exchange/release of information between
(Parent/Guardian)
Cleveland School District and _____ for the specific purposes of
(Name of Agency)
evaluation and placement in the Cleveland School District. 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

_____ Medications

_____ Treatment/ Substances Abuse Planning (to include medications)

_____ Other

I understand that I may revoke this consent at time. I further understand that this consent will expire on _____ and cannot be renewed without my written consent.

_____ _____
School Representative Signature Date Parent/Guardian Signature Date

_____
Witness Signature Date

Student Identifying Data

_____ _____ _____
Complete Name Date of Birth Social Security Number