[PROGRAM NAME/LOGO HERE]

CONSENT FOR RELEASE OF INFORMATION

Student Name:_____Date of Birth _____

Address _____

Home Telephone #:_____Mobile Telephone #: _____

Check and complete the appropriate section:

□ As the parent/legal guardian of the above-named student, I, _____, acknowledge that the student will receive services from [PROGRAM NAME HERE] on-site at the student's home school.

□ I, the above-named student, acknowledge that I will receive services from [PROGRAM NAME HERE] on-site at my home school.

I authorize UPI to release to and receive from the XXX School System medical/school information (the "Records"). I understand that such Records may contain health information pertaining to psychiatric, drug and/or alcohol diagnosis and treatment as well as educational records, immunization records, suspensions/office referral data, attendance data, referrals to the Child Study Team and other student service teams, and written and verbal communication with school staff related to mental health intervention.

In addition, I authorize [PROGRAM NAME HERE] to release identifying student information to [EVALUATORS OR FUNDERS WHO USE PROGRAM DATA] to support program accountability and quality improvement activities.

I understand that the Records will be released and received for the purpose of treatment and quality improvement activities.

[PROGRAM NAME HERE], its employees, officers and medical staff are released from liability for the release of information in accordance with this consent.

Signature of patient or parent/guardian _____

Relationship to Student _____

Date _____

Witness _____

(*This consent is valid one year from the date of signature*)

123 Main Street, City, ST 00000 • 123-456-7890 • 123-456-8790 *fax*

Date last updated: 1/1/2018