VILLAGE TECH SCHOOLS COUNSELING SERVICES

CONSENT TO RELEASE INFORMATION

We, the undersigned, hereby consent to the exchange of information between _____ and the party named below. We understand that the specific information to be released may include, but not limited to history, diagnosis, and/or treatment of drug or alcohol abuse, mental/psychiatric related illnesses or communicable diseases, including Human Immunodeficiency Virus (HIV) and Acquired Immune Deficiency Syndrome (AIDS).

Your Name ____(ENTITY WITH WHICH RECORDS TO BE EXCHANGED)_____
Position _____
School _____
Contact Numbers _____

Student: _____ Date of Birth: _____
Custodial Parent (if Client is under age of 18): _____
Address: _____
Phone: _____

INFORMATION THAT *MAY* BE EXCHANGED

- Entire Psychological Record
- Psychological Evaluation
- Medical History Assessment
- Staffing Summaries
- Treatment Plan(s)
- Psychiatric Evaluation
- Progress Notes
- Diagnostic Summary
- Discharge Summary
- Recommendation for Return to School

For the following purpose(s): _____
Date/condition upon which the consent expires: _____

We fully understand the nature and the intent of the authorization. We understand that our consent is completely voluntary, and we may withdraw this authorization, in writing, at any time. We understand that no services will be denied to us solely on the basis of our refusal to consent to this release of information. We understand that we are entitled to a copy of this authorization. The undersigned parent(s) or legal guardian(s) hereby agree and also consent on behalf of the minor child, when applicable.

_____ _____
Name: Parent(s)/Legal Guardian(s) Date

_____ _____
Name: Parent(s)/Legal Guardian(s) Date