Greeley-Evans
Weld County School District 6
1025 NINTH AVENUE | GREELEY, COLORADO 80631
970-348-6000 | WWW.GREELEYSCHOOLS.ORG

DIVISION OF ACADEMIC ACHIEVEMENT

Student Support Services

CONSENT FOR RELEASE/EXCHANGE OF CONFIDENTIAL INFORMATION

DATE: ______________________

Student Name: ____ DOB: __________

Address: ______________________________ City/State: ____________ Zip Code: __________

This permission shall be valid beginning _______________ and shall terminate _______________.

This consent authorizes the following agencies to release and exchange confidential information about this student.

FROM:		**TO:**	
Agency Name:	____________	Agency Name:	____________
Agency Dept:	____________	Agency Dept:	____________
Contact Person:	____________	Contact Person:	____________
Address:	____________	Address:	____________
City/State/Zip:	____________	City/State/Zip:	____________
Phone:	____________	Phone:	____________
FAX:	____________	FAX:	____________
Email:	____________ (Password Protected Files Only)	Email:	____________ (Password Protected Files Only)

The following checked records are requested to be released and/or exchanged between the above noted agencies.

❒ Audiometric	❒ Educational	❒ Social History
❒ Medical/Health History	❒ Occupational Therapy	❒ Social Work
❒ Psychiatric	❒ Physical Therapy	❒ Counseling
❒ Psychological Records	❒ Speech /Language Therapy	❒ Residential Treatment Records

❒ Other: ____

Return Consent to Release Confidential Information to:

All information released or secured will be in compliance with the Family Education Rights and Privacy Act and the Colorado Open Records Law. No additional information will be released or secured without prior approval from the parent except as provided by law.

❒ YES ❒ NO I understand that consent is voluntary and may be revoked at any time in writing, except to the extent the person/organization has taken action on the request. I hereby authorize the transfer of information as stipulated above.

❒ YES ❒ NO I understand the information disclosed may be subject to re-disclosure by the recipient and may no longer be protected by the HIPAA Privacy Rule.

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Parent/Guardian/Adult Student Signature *Date*

____

Witness Signature *Date*

Revised 6.14