SCHOOL BOARD OF BROWARD COUNTY

AUTHORIZATION FOR RELEASE AND/OR REQUEST FOR INFORMATION

I hereby request and authorize: _____
(Name of Person and/or School/Agency)

_____ to engage
(Street Address) (City) (State) (Zip) (Telephone #)

in verbal and/or written communication with and release records to : _____
(Name of Person and/or School/Agency)

_____
(Street Address) (City) (State) (Zip) (Telephone #)

regarding the **information checked below** concerning my child _____, whose date of birth is _____. I understand that information concerning psychiatric, psychological, medical diagnosis, drug or alcohol abuse and educational information regarding my child may be released and/or communicated. I further understand that this information might contain information regarding my family, in addition to my child.

____ Treatment Plans
____ Discharge Summaries
____ Health/Medical Records
____ School/Education Records
____ Case/Progress/Therapy Notes
____ Exceptional Student Education/Section 504 Records
____ Other _____
____ Other _____
____ Substance Abuse Treatment Records
____ Social and/or Developmental History
____ Psychological and/or Psychiatric Evaluations
____ HIV/Acquired Immune Deficiency Syndrome test results or related conditions

For the Purpose of: _____

All information I authorize to be released or requested will be held strictly confidential and cannot be released by the recipient without an additional written consent. I understand this authorization will expire one (1) year after the date signed, or on _____, 20____, whichever is earlier. A copy of this authorization is valid in lieu of the original. I further understand I may withdraw my consent at any time.

_____ _____
Print Name of Parent or Legal Guardian Signature of Parent or Legal Guardian Date

_____
Relationship to Child

(USE THIS SPACE IF CONSENT IS WITHDRAWN)

_____ _____
Date Consent Is Withdrawn Signature of Parent or Legal Guardian

CROSS CREEK SCHOOL

OUTSIDE AGENCY CONTACTS

STUDENT NAME _____

Case Managers, Mental Health Juvenile Justice/Child & Family Services, etc.

Name	Agency	Phone Number
_____	_____	_____
_____	_____	_____
_____	_____	_____

THERAPIST

_____	_____	_____
_____	_____	_____
_____	_____	_____

PSYCHIATRIST

_____	_____	_____

FAMILY PHYSICIAN

_____	_____	_____
_____	_____	_____

Revised 8/200*