TRINITY CATHOLIC SCHOOLS

AUTHORIZATION FOR RELEASE OF INFORMATION

By signing and dating this release of information, I allow the person or agencies below to share information about this student (if parent signing) or me (when student signs). I understand that this is a cooperative effort by the agencies involved to share pertinent information that will lead to better utilization of community resources and better cooperation amongst our agencies to best meet the needs of this student.

Student Name: ____Grade:______ DOB: __________________

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I hereby authorize the release of counseling related information between Trinity Catholic Schools (representative)________________________________ and the following entities. This may include, but it not limited to, coordination of care and treatment planning for this student.

____

Name(s) of Contact(s)

____

Name of Agency

____

Address

____

City/State/Zip

________________________________ ____________________________

Phone Number Fax Number

____

Email

This consent to share information is valid for one year from the date of signing. I understand that at any time between the signing and the expiration date of this consent, I have the right to revoke this consent and would do so in writing.

Signature:____ Date:__________________

(Parent or Guardian, if student is under 18)