Authorization To Disclose Confidential Information

Student Name:_____ Date of Birth: _____

Student Address: _____ Telephone: _____

_____

I authorize Project STAY - Southeast Kansas Education Service Center – Greenbush to:

☐ release to ☐ obtain from ☐ discuss with

List parties that will be authorized to disclose or receive information:

_____

_____

_____

Information may be exchanged via (check all that apply):

☐ verbally ☐ in writing ☐ email ☐ fax ☐ text message ☐ video conferencing

This authorization should remain valid until _____ or one year from the date listed below.

Faculty, staff, or representative authorized to disclose/receive records:

Project STAY
1104 E 1000 Rd.
Lawrence, KS 66047 T
Phone: 785-690-7081

Authorizing Signature:

1. This authorization for disclosure of confidential records may include pertinent information in the realms of behavioral, educational, medical, psychological, and social histories and is made at my request for the purpose of education. This authorization for disclosure is voluntary. I can refuse to sign this authorization.
2. This authorization may be revoked by me at any time by written request.
3. I authorize the disclosure of the records described. I have read and understand this form. I am the student listed or a legal representative authorized to act on behalf of the student.

_____ _____ _____

Signature of Student or Representative Relation to Student Date