



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.

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

Project STAY
6822 SE Ross St
Topeka, KS 66619
Phone: 785-331-5018
Fax: 877-787-4966

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