

STANLY COUNTY SCHOOLS
CONSENT FOR OBTAINING/RELEASING CONFIDENTIAL INFORMATION

Form to be used with external agencies (physicians, mental health, health facilities, residential facilities, DSS)

INFORMATION OBTAINED / RELEASED BY

Stanly County Schools ATTN: Student Services

Name / Agency / Organization

1000-4 North First Street

Address

Albemarle, NC 28001

704-983-5151 704-982-3618

City / State / Zip

Phone Fax

AGENCY OBTAINING/RELEASING INFORMATION

Name / Agency / Organization

Address

City / State / Zip

Phone

THE FOLLOWING TYPES OF INFORMATION ARE REQUESTED:

- Medical Records
- Psychological/Psychiatric Evaluations, including Treatment Records
- Progress Reports / Other School Information
- Other _____

Informed consent has been explained to me and I understand the contents to be released, the need for the information, and that there are statutes and regulations protecting the confidentiality of authorized information. I hereby acknowledge that this consent is truly voluntary and is valid for one year or until such request is fulfilled. I further acknowledge that I may revoke this consent at any time except to the extent that action based on this consent has been taken. I hereby consent to the release of confidential information contained in the records of:

Full Name of Student

School

Date of Birth

Signed

Relationship to Student

Date

Central Office Copy - White

Agency Copy - Yellow

School Copy - Green