AUTHORIZATION TO OBTAIN/RELEASE INFORMATION

Dawson County Schools
Department of Special Programs
28 Main Street Dawsonville, GA 30534
706-265-3246 Ext. 1007
Fax # 706-216-5720

Student Name:_____DOB:_____FTE#:_____
Parent(s)/Guardian(s):_____
Address:_____
Home Phone #:_____Cell #:_____

Information Requested:

( ) Summary of findings, treatment, recommendations
( )Discharge/Release Summary
( )Treatment Plan(s)
( ) Progress Notes (such as behavioral summaries)
( ) Individual Educational Program
( ) Case History
( ) Medical Record
( ) Psychiatric Report
( ) Psychological Report
( ) Educational Report

( ) Establish open lines of communication for the duration of service. (Open lines of communication will mean the sharing of information on the student's progress/problems by telephone contact or personal contact to maintain a continuity of services among agency providers.)

( ) Other:_____

I hereby authorize Dawson County School System to obtain/release the information indicated above regarding the above-named student from/to:

Agency/Person:_____Address,telephone/fax#:_____

ATTN: The purpose of this information is to assist in the planning, development, and implementation of the above-named student's educational program. All information obtained/released will be held strictly confidential and cannot be requested/released without your written consent.

******I understand this authorization includes the release of medical records which may include information regarding Immunodeficiency Virus (HIV), psychiatric and/or drug/alcohol abuse, venereal disease, and/or any other statutory protected disease. This authorization and consent will expire ONE(1) year following the date signed. I understand that I may revoke consent in writing at any time except that action which has been taken in reliance thereon.******

_____ _____

Signature of Legal Parent/Guardian Date Signature of Witness Date