SOUTH EASTERN SPECIAL EDUCATION
CONSENT FOR RELEASE OF INFORMATION - AUTHORIZATION

Student Name: _____ DOB: _____

Parent/Guardian Name: _____

I, _____ authorize

South Eastern Special Education
PO Box 185
Sainte Marie, Illinois 62459

☐ to release information to ☐ to obtain information from ☐ to exchange information with

Name/Agency: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone: _____ Fax: _____

Information may consist of the following:

- ☐ Psychiatric Evaluation
- ☐ Alcohol/Substance Abuse Assessment
- ☐ Progress Note
- ☐ Vocational Assessments
- ☐ Psychological Evaluation
- ☐ Social History
- ☐ Aftercare Plan
- ☐ Medical Information
- ☐ Mental Health Assessment
- ☐ Treatment Plan
- ☐ Discharge Summary
- ☐ Other: _____

The following has been explained to me and I understand that:

- ❖ Any information released or exchanged by either authorized person or organization is not to be disclosed without my consent in accordance with State and Federal regulations.
- ❖ I can revoke this consent at any time (in writing) except to the extent that action has already been taken.
- ❖ I have the right to inspect and to obtain a copy of the information to be released.
- ❖ Refusal to sign this release may result in delays, duplications and other problems that may affect the quality of services this agency provides.

This authorization expires on: _____ *not to exceed 365 days.

_____ Date: _____
Student Signature (Signature of person 12 years or older required for release of Mental Health Materials)

_____ Date: _____
Parent/Guardian Signature

_____ Date: _____
Signature of Witness

NOTICE TO WHOMEVER DISCLOSURE IS MADE. THIS INFORMATION HAS BEEN DISCLOSED TO YOU FROM RECORDS WHOSE CONFIDENTIALITY IS PROTECTED BY STATE AND FEDERAL LAW. THESE LAWS PROHIBIT YOU FROM MAKING ANY FURTHER DISCLOSURE OF THIS INFORMATION WITHOUT THE SPECIFIC WRITTEN CONSENT OF THE PERSON TO WHOM IT PERTAINS.