

Elite Academy CONSENT TO EXCHANGE INFORMATION

I understand that different agencies provide different services and benefits. Each agency must have specific information in order to provide services and benefits. By signing this form, I am allowing agencies to exchange certain information so it will be easier for them to work together.

I,	, as the Parent or Guardian of					
	Name of Parent or Guardian	Name of Student	Date of Birth			
Ι	consent to the following confidential informa	ation to be exchanged:				

YES	NO		YES	NO	
		Assessment Information			Medical Records
		Psychiatric Records			Psychological Records
		Educational Records			Medical Diagnosis
		Mental Health Diagnosis			

Other information (please specify):

I authorize Elite Academy to be able to exchange the above information with any of the following city or county agencies:

Base School/LEA, Department of Social Services, CSA Coordinators, Human Services Office, 15th District Court Services Unit and/or other (please specify):

Name of Doctor/In-Home Counselor, etc.

I voluntarily allow the release of the above information. No threat or other coercive measures have induced me to sign this consent form.

I may revoke this consent to release information in writing at any time, except where actions have already been taken on the basis of this release. If I do not revoke it earlier, this document will be null and void one year after discharge.

Signature of Parent/Guardian

Date