Release of Information

Po Box 517, Dayton, NV 89403
www.healthycomm.org
Phone: 775-246-7550 ● Fax: 775-246-7553

I hereby authorize the staff of Healthy Communities Coalition and the staff of
____ to release and accept information
Agency name
between one another regarding ____ for the
Student name
purpose of service coordination and program evaluation. I specifically authorize the disclosure of information regarding the following:

_____ Yes _____ No Basic Needs (i.e. food, clothing, hygiene)

_____ Yes _____ No Emotional & Behavioral Needs (Mental Health services)

_____ Yes _____ No Employment

_____ Yes _____ No Family and living situation

_____ Yes _____ No Health & Dental Needs

_____ Yes _____ No Legal History _________________________(Agency Name if applicable)

_____ Other (please specify) ____
____

This authorization shall be valid until 12 months after the student graduates or otherwise becomes unenrolled from the school listed. I understand that I may revoke this release at any time by submitting a written request, but that such a request will not apply to any information exchanged prior to the date of such a request being received.

Parent Signature: ____ Date: ______________

Program Staff: ____ Date: ______________

To those receiving information under this authorization: The information disclosed to you is protected by state and federal law. You are not authorized to release it to any agency or person not listed on this form without specific written consent of the person to whom it pertains unless authorized by other laws.