CONSENT FOR RELEASE OF INFORMATION
Colorado Early Colleges Douglas County

Student Name: ______________________________ Date of Birth ___________________________

Address ____

Home Telephone #: ____________________ Mobile Telephone #: ___________________________

Check and complete the appropriate section:

☐ As the parent/legal guardian of the above-named student, I, ___________________________, acknowledge that the student will receive services from ______________________________ on-site at the student's home school.

☐ I, the above-named student, acknowledge that I will receive services from _________________ on-site at my home school.

I authorize _____________________ to release to and receive from the______________________ School System medical/school information (the "Records"). I understand that such Records may contain health information pertaining to psychiatric, drug and/or alcohol diagnosis and treatment as well as educational records, immunization records, suspensions/office referral data, attendance data, referrals to student service teams, and written and verbal communication with school staff related to mental health intervention.

In addition, I authorize _________________________ to release identifying student information to ______________________________ to support program accountability and quality improvement activities.

I understand that the Records will be released and received for the purpose of treatment and quality improvement activities.

______________________________, its employees, officers and medical staff are released from liability for the release of information in accordance with this consent.

Signature of patient or parent/guardian ____________________________________

Relationship to Student ____________________________________

Date ____________________________________

Witness ____________________________________