

## INTERAGENCY RELEASE OF INFORMATION

By signing and dating this release of information, I allow the persons or agencies listed below to share specific information as checked about this case. I understand that this is a cooperative effort by agencies involved in my case to share information that will lead to better utilization of community resources and better cooperation amongst our agencies to best suit my needs.

Agencies or agency representatives that will be sharing information:

Name	Address	Date

The information to be released is:

- |   |   |
|---|---|
| <input type="checkbox"/> History<br><input type="checkbox"/> Diagnosis<br><input type="checkbox"/> Summary of<br><input type="checkbox"/> Treatment<br><input type="checkbox"/> Medications<br><input type="checkbox"/> School Evaluation<br><input type="checkbox"/> Performance | <input type="checkbox"/> Lab Work<br><input type="checkbox"/> Psychological Assessment<br><input type="checkbox"/> Psychiatric Evaluation<br><input type="checkbox"/> Legal issues/concerns<br><input type="checkbox"/> Other (specify)<br><input type="checkbox"/> |
|---|---|

and is to be released for the purpose of \_\_\_\_\_

This consent to release is valid for one year or until otherwise specified and thereafter is invalid. \_\_\_\_\_  
 Specify date, event or condition permit will expire

You are advised that at any time between the time of signing and the expiration date listed above, you have the right to revoke this consent.

Client/Student Name		Date of Birth		
Address		City	State	Zip Code
Witness	Date	Client/Student Signature (Age 13 years, 9 months and Over)		Date
Position	Signature of Responsible Party, Guardian, if under Legal Age			Date
Relationship to Client/Student				