FORM A

AUTHORIZATION TO RELEASE CONFIDENTIAL INFORMATION

Student Name: _____ **Date of Birth:** _____

Address: _____

(Street Number, Post Office Box, Route Number) (City) (State) (Zip Code)

I, _____**, parent/guardian of the above referenced**

(Name of Parent or Legal Guardian)

student, authorize the following school:

_____

(Student's Current Middle School)

_____

(Street Number, Post Office Box, Route Number) (City) (State) (Zip Code)

to release and exchange the following specific confidential information:

Yes ( ) No ( ) School Counseling Services and Information. Indicate specific information:

_____

Yes ( ) No ( ) Educational Plan. Indicate specific information such as, grades, attendance, etc.:

_____

Yes ( ) No ( ) Legal Information. Indicate specific information such as divorce decree, custody arrangements, etc.:

_____

Yes ( ) No ( ) Medical Information. Indicate specific information:

_____

Yes ( ) No ( ) Psychological Reports. Indicate specific information such as any accommodations, modifications, psychological evaluations, etc.:

_____

Yes ( ) No ( ) Social History. Indicate specific information such as past behavioral or social issues, etc.:

_____

Yes ( ) No ( ) Other: _____ Indicate specific information:

_____

to the following school:

_____

(Name of Catholic High School)

_____

(Street Number, Post Office Box, Route Number) (City) (State) (Zip Code)

The information released may be used by the individual, or the organization represented by the individual for the following purpose(s):

To provide support and counseling services to the above mentioned student.

I understand that: 1) I may revoke this authorization in writing by contacting the Department of Catholic Schools Office or school that obtained the authorization; 2) this authorization will not affect enrollment; and 3) information disclosed as a result of this authorization could be subject to re-disclosure as authorized by law.

EXPIRATION DATE: This authorization will expire on [date or event] _____

(If no date or event is stated, expiration is one year from the signature date.)

_____

(Print / Type Name of Parent or Legal Guardian Authorized to Consent to Release of Information for Student)

_____

(Signature of Authorized Person)

_____

(Address) (Telephone) (Date)

FORM B

DECLINE TO RELEASE CONFIDENTIAL INFORMATION

Student Name: _____ **Date of Birth:** _____

Address: _____

(Street Number, Post Office Box, Route Number) (City) (State) (Zip Code)

I, _____**, parent/guardian of the above referenced**

(Name of Parent or Legal Guardian)

student, decline to sign a release for the counselor at:

_____

(Student's Current Middle School)

_____

(Street Number, Post Office Box, Route Number) (City) (State) (Zip Code)

to release and exchange any information with the following school:

_____

(Name of Catholic High School)

_____

(Street Number, Post Office Box, Route Number) (City) (State) (Zip Code)

_____

(Print / Type Name of Parent or Legal Guardian Authorized to Consent/Decline to Release of Information for Student)

_____

(Signature of Authorized Person)

_____

(Address) (Telephone) (Date)