CONSENT FOR TRANSFER OF CONFIDENTIAL STUDENT INFORMATION TO COMMUNITY AGENCY MENTAL HEALTH SERVICES

School Year _____

This form is completed by the parent/guardian for the purpose of allowing authorized persons, agents and employees in Wicomico County Public Schools to share with and receive information from the agency or person noted below. This exchange of information is intended to support the well-being, academic opportunity and success of the student.

Student's Legal Name: _____
Last Name First Name Middle Name

Student's Address: _____
P.O. Box Street City State Zip Code

Date of Birth: _____/_____/_____ Grade: _____ Social Security Number: _____

Parent(s)/Guardian(s): _____
First Name Last Name

Agency or Person With Whom Confidential Information May Be Shared:

Name/Agency: _____

Address: _____

_____

Phone: _____

Authorized Person Providing Information from Wicomico County Public Schools:

___Principal
___School social worker
___School counselor
___School psychologist
___Student Advisor
___Mental Health Coordinator
___Other (Specify Title) _____

Manner for Release/Exchange of Information (Check all that apply.):

___Verbal communication/exchange ___Email communication/exchange

Reason for Request (Must be completed by agency/person requesting information):
(i.e. provision of counseling services at and during school as approved by parent) **Coordination of Care.**

Parent/Guardian:
I give my permission for authorized persons, agents and employees in Wicomico County Public Schools to exchange with the therapist/agency identified herein updates, concerns and celebrations about my child, _____. I also give my approval for the therapist/agency identified herein to meet with and provide appropriate services to my child at the school during the school day as deemed appropriate by school administration.

_____ _____
Parent/Guardian Signature Date

**This completed form is valid through the final day of instruction for students _____ school year.*