Wakulla County Schools

PARENTAL PERMISSION FOR RELEASE OF INFORMATION
OR REQUEST FOR REVIEW OF STUDENT INFORMATION

Date: ____________________

I, ____
(Parent/Guardian/18 year old Student)

Hereby authorize Wakulla County Schools and

- o **Apalachee Mental Health**, 43 Oak St, Crawfordville, FL 32327
- o **Apalachee, PATH & Eastside Psychiatric Hospital,** 2634-B Capital Circle NE, Tallahassee, Florida 32308
- o **Capital City Youth Services (CCYS),** 2407 Roberts Ave, Tallahassee, FL 32310
- o **DISC Village**, 85 High Drive, Crawfordville, Florida 32327
- o **Department of Children and Families**, 69 High Drive, Crawfordville, Florida 32327
- o **Tallahassee Memorial Behavioral Health Center ,** 1616 Physicians Drive, Tallahassee, FL 32308
- o **Wakulla County Health Department**, 48 Oak St, Crawfordville, FL 32327
- o **Other**____

To exchange information regarding my child/children

Student's Legal Name	Birth Date	School
Student's Legal Name	Birth Date	School
Student's Legal Name	Birth Date	School

Which includes:

☐	Psychological data	☐	Dates of attendance/treatment
☐	Section 504 Records	☐	Treatment Plan
☐	Adaptive behavior scales	☐	Intake Summary
☐	Social/Medical History	☐	Discharge Summary
☐	Present levels of subject area performance	☐	Grades
☐	ESE records including IEP	☐	Other:

This information is to be released for the following purpose(s):

___Counseling ___Coordination of mental health services ___Other: _________________

To: ____
(Name)

____
(Address)

____
(Fax Number)

THESE RECORDS MAY NOT BE RELEASED TO ANOTHER PARTY AND/OR AGENCY WITHOUT PRIOR APPROVAL OF THE PARENT/GUARDIAN AND/OR ELIGIBLE STUDENT.

NOTE: In providing my consent to the release of records, I understand that the information will be released in the form of copies of written records. I have a right to inspect any records released pursuant to this Consent. I understand that I may revoke this Consent by providing written notice to the Principal of the school from which records are being requested. I further understand that until this revocation is made, this Consent shall remain in effect for the current school year and educational records will continue to be provided to the agency specified for the specific purpose(s) listed above. New Parent Consent to Release Student Information forms must be completed for each subsequent school year.

____ ________________________________
Authorized Signature Date Relationship

____ ________________________________
Address Home Telephone

____ ________________________________
City State Zip If no number, please give a number where you can be contacted