Caldwell County Schools

1914 Hickory Blvd SW
Lenoir, NC 28645
Telephone 828-728-8407
Fax 828-728-0012

Dr. Don Phipps, Superintendent

Consent to Release Information

I give permission for the people or agencies listed below to share specific information about my child,

_____ _____
(Child's name) **(DOB)**

with _____ at _____ .
(Staff members) **(School)**

Specific information to be shared shall include:
_____
_____
_____.

This consent will expire on a date no more than 12 months from date of signing.

- I understand that the information obtained in this process will only be shared and used for the screening, assessing, planning, delivering, and monitoring of appropriate academic, physical health, mental health, social, and legal services for my child.
- I understand that this is a cooperative effort by the agencies involved with my child to share information that will lead to better utilization and cooperation of community resources to best meet my child's academic, physical health, mental health, social, and legal needs.
- I understand that the members of the School Based Support Team know that my child's records are confidential and will not be released or shared to any agency or individual not included in this Consent without my prior written consent.
- I understand that I have the right to revoke this consent at any time between the time of signing and the expiration date listed above.
- I understand that I have a right to a copy of this release.

Agencies that I give permission to share information (Use back for additional entries):

AGENCY/PERSON	ADDRESS

_____ _____
(Signature of Parent or Guardian #1) (Print Name of Parent or Guardian #1)

_____ _____
(Signature of Parent or Guardian #2) (Print Name of Parent or Guardian #2)

_____ _____
(Signature of Witness) (Print Name of Witness)

_____ _____
(Date of Consent) (Expiration Date – no more than 12 months after Date of Consent)