Jocelyn Smith, District Administrator 715-358-3789 Fax Rich Fortier, Principal

RELEASE OF CONFIDENTIAL INFORMATION AUTHORIZATION

Completion of this form authorizes the release of information described below. The parent/guardian who authorizes this release may have a right to inspect these records and to receive a copy of this authorization. You have the right to refuse to sign this authorization. You understand that you have the right to cancel this authorization, in writing at any time, except for information already released as a result of this authorization. You understand that these records are protected under Wisconsin State statutes governing confidentiality and cannot be disclosed without your written consent unless otherwise provided for in state statute.

I Hereby Authorize: Arbor Vitae-Woodruff Elementary School District
11065 Old Hwy. 51 N
Arbor Vitae, WI 54568

☐ TO RELEASE TO:

____

Name and/or Agency and Address

☐ TO OBTAIN FROM:

____

Name and/or Agency and Address

Records Of: ____ _________________

Student's Name Date of Birth

Purpose of need for disclosure:

____
____
____

Information to be Disclosed:

____ School Records
____ Medical Reports/Physical Exams
____ Psychological Assessment
____ Psychiatric Evaluation (includes diagnosis/prognosis)
____ Alcohol or Drug Evaluation/Treatment
____ Other (Describe):

____ Treatment Plan
____ Social History
____ Treatment Summary
____ Discharge Summary
____ Legal Status/Offenses

____
____
____

Unless revoked by me in writing, this consent expires on: ________________________________

Date

____ _____________________

Parent/Guardian Date Signed

____ _____________________

District Employee Signature Date Signed