AUTHORIZATION FOR RELEASE OF INFORMATION

Last Name **First** **Middle** **Date of Birth**

Social Security Number:

I hereby give permission for

Records Custodian for Good Shepherd Services

to release to

(Name and address of person, agency or organization)

the following information contained in my record:

The information disclosed will be used solely for the purpose of

This consent specifically authorizes the Records Custodian for Good Shepherd Services to disclose medical records.

This consent is subject to revocation at any time except to the extent that the Custodian, which is to make the disclosure, has already taken action in reliance on it. If not previously revoked, this consent will terminate upon:

(Specific Date, Event, or Condition)

I understand that I may withdraw my permission at any time by notifying the Records Custodian for Good Shepherd Services in writing.

Witness Signature **Signature of Student** **(Date)**

Printed Name of Parent/Guardian **Signature of Parent/Guardian** **(Date)**

Relationship to Student

PROHIBITION ON REDISCLOSURE

This information has been disclosed to you from records whose confidentiality is protected. Any future redisclosure is prohibited unless permitted in accordance with state and federal law.