Wake County Public School System
Counseling and Student Services

Release of Information

Doctor/Medical Provider ____

Address ____

____

I authorize the reciprocal release and exchange of psychological/mental health/medical information between the above service provider and Wake County Public School System (WCPSS) staff in carrying out or planning supportive interventions for my child.

______________________________ ______________
(Student Name) (Birth date)
to the following agency:

____
____
____

Attention of: ____

I understand the information will be used to support and improve school attendance and the academic success of my child.

My right to confidentiality has been explained to me and I understand what information will be released, the need and purpose for the information and that there are statues and regulations protecting the confidentiality of authorized information. I hereby acknowledge that this consent is voluntary. I further acknowledge that I may revoke this consent at any time except to the extent that action based on this consent has been taken. This release of information form will expire on _________ without any additional action.

Information needed: *(psychological/mental health/medical records or summaries, via written record and/or consultation)*

______________________________ ______________________________
Parent/Guardian Name Parent/Guardian Signature

______________________________ ______________________________
Street Address Date

______________________________ ______________________________
City Witness Date