

Consent To Release Information	NAME: DATE OF BIRTH: Student ID#:
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Extent or Nature of Information to be Disclosed

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| ❖ <input type="checkbox"/> 1. Psychological evaluation
❖ <input type="checkbox"/> 2. Academic Performance
<input type="checkbox"/> 3. Social, Behavioral assessments | <input type="checkbox"/> 4. Medical Records
<input type="checkbox"/> 5. Agency assessment and involvement
<input type="checkbox"/> 6. Other (specify) |
|--|---|

Purpose or need for information:
 This information is requested to aid in provision of services of the above named student.

FROM: Name, address, and title of person/organization/facility/program disclosing information.	TO: Name, address, and title of person/facility/program to which disclosure is to be made. Roxanne McCarty Learning Specialist Center for Accommodative Services Paul Smith's College Paul Smith's, NY 12970 FAX (518) 327-6369
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A. I hereby authorize the one-time release of the above information to the person/organization/facility/program identified above. I understand that the information released is confidential and protected from disclosure. I also understand that I have the right to cancel in writing my permission to release information at any time, except to the extent that it has already been acted upon.

My consent to release information will expire when acted upon or 90 days from this date, whichever occurs first.

Signature of client/ Parent if required	Relationship	Date Signed	Signature of Witness	Title	Date Signed
	self				

B. I hereby authorize the periodic release of the above information to/from the persons/organizations/facilities/programs identified above as often as necessary to provide for/provide care and services. I understand that the information released is confidential and protected from disclosure. I also understand that I have the right to cancel in writing my permission to release information at any time, except to the extent that it has already been acted upon.

My consent to release information will expire when I am no longer receiving services from Paul Smith's College.

Signature of client/ Parent if required	Relationship	Date Signed	Signature of Witness	Title	Date Signed
X	X	X	X	X	X

Record of information released

Signature of staff person releasing information	Title	Date Released