**AUTHORIZATION FOR RELEASE OF STRICTLY CONFIDENTIAL INFORMATION**

**TO LOCAL STAFF OR VOLUNTEERS**

**I give my permission to release information contained in the document(s) indicated below:**

Please date, initial and check [🗸] the appropriate items below.

Date Initials Check Item

\_\_\_\_\_ \_\_\_\_\_\_ [ ] Learning Needs Screening

\_\_\_\_\_ \_\_\_\_\_\_ [ ] Other:

\_\_\_\_\_ \_\_\_\_\_\_ [ ] School records from:

\_\_\_\_\_ \_\_\_\_\_\_ [ ] Other records from:

**I give permission to release the information contained in the documents indicated above to the following individuals for educational or assessment purposes:**

If the same information can be made available to several staff people, please list their names below. Then date, initial and check [🗸] the appropriate individuals. If different information is going to various individuals, use separate forms.

Date Initials Check Staff Member Date Initials Check Staff Member

\_\_\_\_\_ \_\_\_\_\_ [ ] \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_ \_\_\_\_\_ [ ] \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_ \_\_\_\_\_\_ [ ] \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_ \_\_\_\_\_ [ ] \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_ \_\_\_\_\_\_ [ ] \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_ \_\_\_\_\_\_ [ ] \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_ \_\_\_\_\_ [ ] All of the Staff Members Listed above

\_\_\_\_\_ \_\_\_\_\_ [ ] Other Individual(s):

\_\_\_\_\_ \_\_\_\_\_ [ ] Volunteer Tutor:

**This release is valid for one year from the date of my signature or until it is revoked in writing, whichever occurs first. This release has been read out loud to me and I understand its contents.**

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:

Signature of staff person releasing the information:

**AUTHORIZATION FOR RELEASE OF CONFIDENTIAL INFORMATION**

**TO EXTERNAL AGENCY INDIVIDUALS**

**I give my permission to release information contained in the document(s) indicated below:**

Please date, initial and check [🗸] the appropriate items below.

Date Initials Check Item

\_\_\_\_\_\_\_ \_\_\_\_\_\_\_ [ ] Learning Disabilities Screening

\_\_\_\_\_\_\_ \_\_\_\_\_\_\_ [ ] Test of Adult Basic Education (TABE) scores

\_\_\_\_\_\_\_ \_\_\_\_\_\_\_ [ ] GED Official Practice Test (OPT) scores

\_\_\_\_\_\_\_ \_\_\_\_\_\_\_ [ ] Attendance records

\_\_\_\_\_\_\_ \_\_\_\_\_\_\_ [ ] Other:

\_\_\_\_\_\_\_ \_\_\_\_\_\_\_ [ ] School records from:

\_\_\_\_\_\_\_ \_\_\_\_\_\_\_ [ ] Other records from:

**I give permission to release the information contained in the documents indicated above to the following agency individuals for educational and assessment purposes:**

[If the same information is going to several agencies, date, initial and check [🗸] the appropriate agencies below. If different information is going to several agencies, use a separate form for each agency.]

Date Initials Check Agency/Individual

\_\_\_\_\_\_\_ \_\_\_\_\_\_\_ [ ] Arkansas Rehabilitation Services (ARS)

ARS Designated Individual(s): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_ [ ] Department of Health and Human Services (DHHS)

DHHS Designated Individual(s): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_ \_\_\_\_\_\_\_ [ ] Other Agency:

Other Agency Individual(s):

**This release is valid for one year from the date of my signature or until it is revoked in writing, whichever occurs first. This release has been read out loud to me and I understand its contents.**

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:

Signature of staff person releasing the information:

**REQUEST FOR CONFIDENTIAL INFORMATION**

Client Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(last, first, middle)

Other Last Name(s) Used: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(for those who changed their name due to marriage, adoption, etc.)

Client Address:

Client Telephone:

Social Security #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth:

**AUTHORIZATION FOR RELEASE OF INFORMATION**

I , \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, a student in the Adult Basic Education Program in \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ County, Arkansas, authorize \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ to release to the Adult Basic Education Program the indicated information (check and initial all items that apply) for educational and assessment purposes:

\_\_\_\_\_\_\_ All educational records **including psychological or achievement test results** as well as special education files which might contain my Individualized Education Plan (IEP)

\_\_\_\_\_\_\_ All evaluations or diagnostic reports related to cognitive processing/learning

\_\_\_\_\_\_\_ All medical records or other information regarding my treatment including psychological or psychiatric condition

\_\_\_\_\_\_\_ Other:

Please send this information to:

Attention:

Agency:

Address:

This release is valid for one year from the date of my signature, or until it is revoked in writing by me. I understand the information will be kept confidential and will not be shared with another agency without consent. This release form has been read out loud to me and I understand its contents.

Client's Signature: Date:

Witness Signature: Relationship: