CONSENT TO RELEASE CONFIDENTIAL ALCOHOL OR DRUG ABUSE INFORMATION

I, _____, do hereby consent to and authorize
(Name of student- please print)

_____to
(Name and Address of Person/Agency making the disclosure)

disclose to _____.
(Name and Address of person/agency receiving the disclosure)

the following information (**circle Y for Yes or N for No for each type of information**)

	Information Type		**Information Type**		**Information Type**
Y N	Drug and Alcohol Information	Y N	Test (UA) Results	Y N	Discharge Summary/ Plan
Y N	Discipline Record	Y N	Medication Prescribed	Y N	Treatment Plan/ Support Agreement
Y N	Academic Record	Y N	Assessment Summaries/Evaluations	Y N	Treatment Recommendations
Y N	Family History	Y N	Behavior Support Plan	Y N	Diagnosis/ Presenting Problem
Y N	Attendance	Y N	Other (specify)	Y N	Other (specify)

I agree to have information exchanged between both parties reciprocally: Yes No

The purpose of this disclosure is: _____

_____.

Time period or other specifics related to the information to be disclosed: _____

_____.

Means of Disclosure (check all that apply) □Written □Oral □Electronic □ Fax

I understand that federal regulations (42 CFR part 2) prohibit the redisclosure of drug and alcohol information without my written consent or as allowed by the regulations. I understand that under Vermont statute, my health information can only be disclosed with my authorization or as mandated by an express provision of law. I understand that I may revoke this authorization at any time except to the extent that the agency, or other agency making the disclosure, has already acted in reliance on it. This revocation should be submitted in writing to the address below:
Kyle Bouchard
Lamoille Union High School
736 VT Rte 15 West
Hyde Park, VT 05655

Student Signature: _____ Date:_____

Witness Signature:_____ Date:_____

Parent/Guardian Signature:_____ Date:_____