HANDS
3800 1st Avenue South, Room 8
Great Falls, MT 59405
(406) 268-6932

OFFICIAL RELEASE OF CONFIDENTIAL INFORMATION

In order to create a seamless transition between your child's school day and our after school program, we request your permission to allow the HANDS head teacher to confer with your child's teacher or principal concerning issues that apply to your child. You will be notified of any conversations that are held.

Date:_____

Student Name:_____ Birth Date:_____

Parent/Guardian Name and Address:

_____
_____
_____
_____

___ **I authorize the released information to be exchanged with _____**
(HANDS Head Teacher)

___ **I authorize the released information to be exchanged with the HANDS Director**

Reason for Requesting Information:_____

I hereby authorize the above mentioned agency or individual to (check all that apply):

_____ Release Information to GFPS

_____ Obtain Information from GFPS

The information to be released (check all that apply):
____ Teacher, Counselor, or Staff Observations
____ Any medical information that will help HANDS staff better care for child
____ Any information on behavioral management techniques used in classroom that could be carried over to after-school program

AUTHORIZATION

This authorization is valid for one calendar year. It will expire _____(insert date)
I understand that I may revoke this authorization at any time by submitting written notice of the withdrawl of my consent. I recognize that this information once received by the HANDS Program, may not be protected by the HIPAA Privacy Act.

_____ _____
Signature of Parent/Guardian Date