Consent to Release Private Data

To All Parents

By signing this release of information form, you give (School's Name) _____ the permission to release, obtain, and exchange your student's information with VEEMAH.

Student's Name:_____

Date of Birth: _____

1. Parents/Guardian Name: _____
2. Parents/Guardian Name: _____

Address: _____

Phone Number 1: _____ Phone Number 2: _____

Cellphone 1: _____ Cellphone 2: _____

Email: _____

Insurance Information

Group number: _____

ID number: _____

If you have private insurance:

Insurance Company Name: _____

Name of Insured: _____

Date of birth of Insured:_____

Address of Insured: _____

Group number: _____

ID: _____

I, _____authorize, (School's Name)
_____ to

☐Release my student's information to **VEEMAH Integrated Wellness and Consulting Services, LLC**

☐To Obtain information from **VEEMAH Integrated Wellness and Consulting Services, LLC**

For the purpose of:

☐Collaboration of Care for school-based mental health therapy

Initials: _____ I understand that the purpose of this release is to authorize my child's school to share parent and student contact information with VEEMAH.

Initials: _____ I give permission to (School's Name) _____ to release IEP/504 Plan information as a part of this consent.

I understand that this authorization takes effect the day that I sign it or no more than one year from the date of my signature. I can rescind my authorization in writing at any time by sending my request to VEEMAH Integrated Wellness and Consulting Services, LLC located at 5701 Kentucky Avenue North, Suite 100, Crystal, MN 55428.

Signature: _____ Date: _____