AUTHORIZATION FOR THE RELEASE OR EXCHANGE OF INFORMATION

Participant Name: _____

Information To Be Released Or Exchanged With **Kunnectionz/Parentz@Work** Staff Member/Facilitator:

_____

Name: _____Your relation: _____

Address: _____

Information To Be Released Or Exchanged:

- ❑ Attendance Record
- ❑ Participation
- ❑ Number of Court-ordered sessions

_____

This authorization shall become effective immediately and expire in one year. A scanned copy, photocopy, or fax of this form is to be considered as valid as original. Authorization of disclosure of your mental health information to someone who is not legally required to keep it confidential may be redisclosed and may not be protected.

Your Rights:

1. You may refuse to sign this authorization.
2. You have the right to revoke this Authorization by writing to your Parent Educator. Your revocation will be effective when received. This revocation, however, will not extend to information that was already obtained or released prior to the revocation.
3. You can receive a copy of this Authorization.

_____ _____

Participant Signature Date