



Georgia Pines G.A.P. Team

A School Based Mental Health Program

706-521-4GAP (4427)

Authorization for Release of Information

Student's name: _____ Date of Birth: _____

I authorize the following agencies and individuals to exchange confidential health and education information pertaining to the above named child/student:

_____ School System

And

Georgia Pines Community Service Board

I authorize the release of any and all mental health and educational records between the above named agencies and individuals. I authorize all verbal and/or written information to be released/exchanged between the above agencies and individuals for the purpose of providing behavioral health assessments, individual/group therapy, and community support services and planning for mental health care services and treatment in school.

I understand that I may revoke this consent at any time by providing written notice and will hold all agencies harmless for information released prior to written revocation. After one year this consent automatically expires. I have been informed what information will be given, its purpose, and who will receive the information.

Parent/guardian signature: _____ Date: _____