

**Catholic Human Services, INC. / G.I.S. Student First Prevention Program**  
Authorization for Release of Information

Child's Name: \_\_\_\_\_ D.O.B. \_\_\_\_/\_\_\_\_/\_\_\_\_

Person/ Organization providing and receiving information:

**Catholic Human Services**  
**1665 West Elk view Dr.**  
**Gaylord, MI 49735**  
**(989)-732-6761**

Person/Organization to provide and receive information:

**Gaylord Intermediate Schools**  
**240 E. Fourth St.**  
**Gaylord, MI 49735**  
**(989)-731-0856**



Initial box

I authorize the above named organizations to release information to each other.

**Information to be released:** May include: behavioral referrals, attendance records, academic records, and /or any health records that are deemed important for the success of the child as relates to the prevention program.

**Purpose for the use or release of information:** G.I.S. School Success Prevention Program & small group work.

**I understand the following:**

- This authorization is voluntary and I may revoke it at any time verbally or in writing.
- I may refuse to sign this authorization and my treatment and care will not be affected by refusal.
- The information disclosed or released may be subject to redisclosure by the recipient and thereby no longer protected by federal privacy regulations (HIPPA)
- I will be informed if the person requesting information is to receive financial or in-kind compensation in exchange for using or disclosing the health information described above.
- I am entitled to receive a copy of this authorization
- This authorization is effective from the date signed below and will automatically expire 12 months from the date of signature or at discharge, unless specified:

Date to Expire: \_\_\_\_\_

Event or Program: \_\_\_\_\_

Date of signature: \_\_\_\_/\_\_\_\_/\_\_\_\_

Signature of individual or individual's legal representative: \_\_\_\_\_

Printed name of legal representative and relationship to individual: \_\_\_\_\_