AUTHORIZATION FOR RELEASE OF CONFIDENTIAL INFORMATION

Participant Name: _____

Participant Name: _____

Children's Names:

_____ *Date of Birth* _____
_____ *Date of Birth* _____
_____ *Date of Birth* _____
_____ *Date of Birth* _____

I authorize: The Improving School Attendance Collaborative (ISA) Staff

☒ To give records to: ☒ To receive records from: ☒ To verbally exchange information with the following agencies, providers, or persons:

_____

_____

Records requested:

☐ Medical ☐ Housing ☐ Education ☐ Special Education ☐ Attendance ☐ Employment

☐ Other: _____

I hereby authorize the release of the above information. I understand that such information cannot be released without my specific authorization. I may revoke this authorization in writing at any time. I understand that the revocation will not apply to information that has already been released in response to this authorization.

This authorization will expire in one (1) year.

_____
PRINT NAME

_____
SIGNATURE DATE

_____
PHONE EMAIL

ISA Staff work for ChildStrive, Housing Hope, Interfaith Family Shelter, Refugee & Immigrant Services NW, and YWCA.