



Authorization for Exchange of Confidential Information

Student Name: _____

D.O.B.: _____

I hereby authorize the exchange of confidential information between:

_____, *Everett Public Schools*, and:
Name Position

Name of person/agency: _____

Address: _____

Phone: _____ eMail: _____

Extent and nature of information to be disclosed: _____

Purpose/need for information: _____

I understand that the information obtained will be treated in a confidential manner and will not be transmitted to a third party without my written permission. I also understand that I may revoke this authorization to release information at any time by providing written notice to:

_____.
Name Position

I understand that any information released prior to my revocation of this authorization shall not be a breach of my confidentiality.

This authorization includes the exchange of information between:

_____, _____, _____,
_____, _____, _____,

Further, I understand that I have a right to receive a copy of this authorization.

This authorization is effective from the date of execution until: _____

Parent/ Guardian Signature _____ Date: _____

Student Signature _____ Date: _____

Witness Signature _____ Date: _____