AUTHORIZATION FOR COUNSELING AND RELEASE OF INFORMATION

I/WE hereby grant Laura Heisler, school counselor, permission to see

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Student’s Name

for counseling during the academic year 2015-2016.

I/WE further authorize the counselor to release information or to secure information from personnel at St. Anthony’s, in efforts to coordinate counseling and academic services for the above named student.

I/WE understand that this authorization shall remain valid from the date of my/our signature(s) until the end of the academic year specified.

I/WE have been informed that I/WE may revoke this authorization by written communication.

I/WE certify that this form has been fully completed and explained to me/us and that I/WE understand its contents.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Parent/Guardian

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Parent/Guardian

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Counselor