Multi-Party Consent to Release/Exchange Information

The youth/student whose information may be released:

Name:_____D.O.B_____

Listed below are agencies that provide services for children and their families. The purpose for this release/exchange of information is to help coordinate services, provide appropriate programs and services, and to ensure the child and family receive services as quickly as possible. Initial next to the agencies that can collaborate for your child.

Initials	Agency/Program
	Educational Service Unit #2 (2320 N. Colorado Ave)
	School District, specify:
	Physician/Clinic/Therapist/Hospital, specify:
	Nebraska DHHS
	Legal / Juvenile Justice
	Other, Specify:

I give my consent as the parent/guardian of the minor child, to the agencies identified above to share the information that I have initialed:

Initials	Type of Information
	Medical- Personal Health Information (PHI)- List any exceptions:
	Mental Health Information including Alcohol, Drug and Substance Abuse Records- List any exceptions:
	Educational Records- List any exceptions:
	Legal/Juvenile Justice - List any exceptions:
	Other:

Explanation of Rights: I understand that:

1) I may revoke this release prior to the expiration period set forth below by providing written notice of revocation to the school or the disclosing party,
2) I have the right to receive a copy of such records upon request,
3) If I do not give my consent to share information, my student's existing educational services will not be withheld,
4) If I do not give my consent to share information, the agencies may not be able to determine the best services available for my child and family; and
5) I am authorizing disclosure of information protected under federal law. This information, once disclosed, may be subject to re-disclosure by the recipient and no longer protected by state or federal law.

_____ _____

Signature of Parent/Guardian Date

_____ _____

Printed Name of Parent/Guardian Relationship to Client/Youth

Unless otherwise stated, this release is valid for one year from the date listed above.
By signing this form you permit the providers listed to disclose and receive confidential personal health information.

Revised August 2020