Divergent Insights Release of Information

STUDENT / CLIENT INFORMATION

Name of Student / Client

DOB

TWO-WAY AUTHORIZATION

I authorize Divergent Insights and the individual/organization identified below to disclose, obtain, and exchange information with one another as specified in this authorization.

Individual / physician / agency / clinic / hospital / school / other

Phone

Address

Email / Fax

INFORMATION / RECORDS AUTHORIZED FOR RELEASE OR EXCHANGE

- ☐ Academic records
- ☐ IEP / special education records
- ☐ Case study components
- ☐ Medical information
- ☐ Specialized reports
- ☐ Mental health records
- ☐ Drug abuse / dependency information
- ☐ Attendance / behavior records
- ☐ Other

Other records / specific information (describe)

SPECIFIC LIMITATIONS OR RECORDS EXCLUDED FROM THIS AUTHORIZATION

PURPOSE / REASON FOR REQUEST

- ☐ Transfer / coordination of services or educational programming
- ☐ Evaluation, case study, assessment, or school performance concerns
- ☐ Another agency / district is requesting information for possible services
- ☐ Records management / lawful records retention or destruction
- ☐ Other (specify) _____

AUTHORIZATION TERMS

- This authorization is voluntary. It is limited to the information and records identified in this form and may be used only for the purpose(s) stated above.
- I understand that I may revoke this authorization in writing at any time, except to the extent that action has already been taken in reliance on it. Revocation does not apply to information already disclosed under this authorization.
- Unless I enter an earlier expiration date below, this authorization expires one (1) year from the date signed.
- I understand that information disclosed under this authorization may be subject to applicable federal and state confidentiality laws. Certain specially protected records may require additional consent or may not be redisclosed except as permitted by law.

Authorization limited specifically to records pertaining to:

Earlier expiration date (optional) _____ *If blank, expires one year from date signed.*

SPECIAL CONSENT

- ☐ Student consents to release/exchange of mental health records, if applicable.

Use when student consent is required by applicable law or policy (including age-based requirements).

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PARENT / GUARDIAN / AUTHORIZED REPRESENTATIVE

Printed name _____ Relationship _____

Signature _____ Date _____

STUDENT SIGNATURE (IF APPLICABLE)

Signature _____ Date _____

DIVERGENT INSIGHTS CONTACT / DESTINATION

Name, address, phone, email, fax, or other contact details for Divergent Insights:

OPTIONAL RECORD RECEIPT / OFFICE USE

I, _____ received the above-mentioned record(s) on _____

Additional notes