

**AUTHORIZATION TO RELEASE AND CONSENT TO EXCHANGE INFORMATION**

I/We, \_\_\_\_\_,

I am/are the (Check one):

Parent(s)                       Legal Guardian                       Agent Acting Pursuant to a Power of Attorney, for

\_\_\_\_\_  
(Name/student)

\_\_\_\_\_  
(Date of Birth)

My/our mailing address:

**AUTHORIZATION**

I authorize the following agencies and individuals to exchange confidential information pertaining to above named child/student:

(Agency Name, Title, and name of Specific Staff Contact Person or Designee)  
AND

(Agency Name, Title, and name of Specific Staff Contact Person or Designee)

Additional agencies who may exchange information are listed on the back

Yes       No

**SOURCE AND TYPE OF INFORMATION**

My consent to the exchange of information (except drug or alcohol abuse diagnoses or treatment information) applies to the following sources of information (initial all that apply):

YES	NO	
<input type="checkbox"/>	<input type="checkbox"/>	Assessment Information
<input type="checkbox"/>	<input type="checkbox"/>	Psychiatric Records
<input type="checkbox"/>	<input type="checkbox"/>	Educational Records
<input type="checkbox"/>	<input type="checkbox"/>	Psychological Records
<input type="checkbox"/>	<input type="checkbox"/>	Mental Health Diagnosis
<input type="checkbox"/>	<input type="checkbox"/>	Benefits/Services Information

YES	NO	
<input type="checkbox"/>	<input type="checkbox"/>	Financial Information
<input type="checkbox"/>	<input type="checkbox"/>	Medical Diagnosis
<input type="checkbox"/>	<input type="checkbox"/>	Medical Records
<input type="checkbox"/>	<input type="checkbox"/>	Employment Records
<input type="checkbox"/>	<input type="checkbox"/>	Criminal Justice Information

Other Information that may be released or exchanged (specify): \_\_\_\_\_

The form of information that may be exchanged: (initial all that apply):      \_\_\_\_\_ Written      \_\_\_\_\_ Verbal      \_\_\_\_\_ Computerized Data

This information may be exchanged for the following purposes: (initial all that apply):

\_\_\_\_\_ Service Coordination and Treatment Planning      \_\_\_\_\_ Eligibility Dtermination

\_\_\_\_\_ Other (specify): \_\_\_\_\_

**ACKNOWLEDGEMENT**

I have read and understand this authorization and consent will remain effective until I revoke it by notifying the agencies or individuals orally or in writing. This will stop the exchange of information authorized by this document. I understand that I have the right to know what information is being exchanged, and why, when, and with whom it was shared. At my request, the named agency or individuals will show me this information. A copy of this signed authorization and consent is valid to exchange information. If I do not sign this form, information will not be exchanged and I will have to contact each agency individually.

Print Name: \_\_\_\_\_ Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Print Name: \_\_\_\_\_ Signature: \_\_\_\_\_ Date: \_\_\_\_\_

See Privacy Act Statement - Page 2

### PRIVACY ACT STATEMENT

In accordance with the Privacy Act of 1974 (Public Law 93-579), this notice informs you of the purpose for collection of information on this form. Please read it before completing the form.

**AUTHORITY:** 10 U.S.C. 5013, Secretary of the Navy; 10 U.S.C. 5041, Headquarters, Marine Corps; and E.O. 9397 (SSN).

**PRINCIPAL PURPOSE:** Information collected by this form will be used to prove parent consent to share information. The information collected on this form will be filed within a Privacy Act Systems of Records collection governed by Privacy Act System of Records Notice MO 1754-6 which can be downloaded at <http://privacy.defense.gov/notices/usmc/MO1754-6.shtml>.

**RETENTION AND SAFEGUARDS:** SAMPLE: The collected information will be maintained in a database with restricted, limited access by authorized personnel who are properly screened, cleared, and trained. The database is protected by password, unique user IDs, and applicable layers of security access within applications. Records in this file system will only be retrieved by name and social security number. Records will be maintained indefinitely until a records disposition is approved.

**ROUTINE USES:** To various officials outside the Department of Defense specifically identified as a Routine Use in Privacy Act System of Records Notice MO 1040-2 for the stated specific purpose in addition to those set out in the blanket routine uses established by the Department of Defense Privacy Office and posted at <http://www.defenselink.mil/privacy/notices/blanket-uses.html>.

**DISCLOSURE:** Providing information on this form is voluntary (select one). Note: If parent does not complete the necessary data fields, EFMP will be unable to communicate with identified outside agency.