CONSENT TO COMMUNICATE FORM

For the purpose of providing the most appropriate instruction and assistance in school, I give permission for communication concerning:

Name of Student_____ Date of Birth_____

School Enrolled_____ Grade Level_____

Between CSC of Eastern Hancock County and the following:

_____
(Hospital, Clinic, Physician, Institution, Association or School)

_____
(Address of Above)

Name of Medical Contact Person: _____ Phone _____

Name of School Contact Person: _____ Phone _____

I understand that: (1) I have a right to revoke this authorization in writing at any time, except to the extent communication has already been made in reliance upon this authorization. (2) The information released in response to this authorization may possibly be re-disclosed to other parties. (3) My treatment or payment for my treatment cannot be conditioned on the signing of this authorization.

This authorization shall be in force and effect until the Student is no longer enrolled at any school served by CSC of Eastern Hancock County at which time this authorization expires.

Signature of Person Giving Consent_____

Relationship_____Phone_____

Address_____Zip_____

Date Signed_____

Please Return To_____

10370 E. 250 N., Charlottesville, IN 46117 Tel: (317) 936-5444 Fax: (317) 936-5516