

Alleghany Highlands Public Schools

Two-Way Consent to Exchange Information

I understand that different agencies provide different services and benefits. Each agency must have specific information in order to provide those services and benefits. By signing this form, I am allowing agencies to exchange certain information so it will be easier for them to work together effectively to provide or coordinate these services for my child.

I, _____, am signing this form for _____

(Full Printed Name of Parent/Guardian/Surrogate)

(Full Printed Name of Student)

residing at _____ Date of Birth _____

(Student's Address)

My relationship to this Student is: ☐ Parent ☐ Power of Attorney ☐ Other Legally Authorized Representative

I want the following confidential information about the client (Excluding drug or alcohol abuse diagnoses or treatment information) to be exchanged:

Yes	No		Yes	No		Yes	No	
<input type="checkbox"/>	<input type="checkbox"/>	Assessment Information	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	School Records
<input type="checkbox"/>	<input type="checkbox"/>	Other Placement Information	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	Prior Services
<input type="checkbox"/>	<input type="checkbox"/>	Sociocultural Info.	<input type="checkbox"/>	<input type="checkbox"/>	Mental Health Records	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/>	<input type="checkbox"/>	Medical Records	<input type="checkbox"/>	<input type="checkbox"/>	Psychological Records	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/>	<input type="checkbox"/>	Speech/Language/ Hearing records	<input type="checkbox"/>	<input type="checkbox"/>	Developmental Records	<input type="checkbox"/>	<input type="checkbox"/>	

I agree to an exchange of information between the following individuals or agencies:

Alleghany Highlands Public Schools <hr/> <hr/> <p>Agency/ Individual Name</p> <hr/> <p>PO Drawer 140, Low Moor, VA 24457</p> <hr/> <p>Address</p> <hr/> <p>(540) 863-1809 FAX (540) 863-1822</p> <hr/> <p>Phone and FAX Numbers</p>	<hr/> <hr/> <p>Agency/ Individual Name</p> <hr/> <hr/> <p>Address</p> <hr/> <hr/> <p>Phone and FAX Numbers</p>
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and all Alleghany Highlands Public Schools personnel who would be involved in serving my child.

I want this information exchanged ONLY for the following purpose(s):

☐ Eligibility Determination
☐ Provision of IEP or 504 Services
☐ Other (Write in): _____

I want information to be shared (check all that apply): ☐ In Writing ☐ In Meetings
☐ Phone ☐ Computer

This consent is good for one year from the date consent is granted; however, I can withdraw this consent at any time by telling the agencies involved.

Parent/Guardian/SurrogateSignature: _____ Date _____

Person Explaining Form: _____ Date _____