

Martinsville City Public Schools

CONSENT TO EXCHANGE INFORMATION

To provide the best service for your child, various community agencies must share information from time to time. By signing this form, I am allowing the involved agencies to exchange certain information, enabling them to coordinate efforts that will maximize the benefits for my child.

I, _____, am signing this form on behalf of my
(full printed name parent or guardian)
child _____ Birth date: _____
(full printed name of child)
Address: _____

I want to have the following confidential information about my child to be shared: *(check all that apply)*

- Medical Records (Summary including diagnoses and current medications) Other _____
 Mental Health Records (Summary including diagnoses and current medications) Other _____

___ School Nurse Albert Harris Elementary School 710 Smith Street Martinsville, VA 24112 276-403-5838 276-632-3069 (fax)	___ School Nurse Patrick Henry Elementary School 1810 Church Street Ext. Martinsville, VA 24112 276-403-5812 276-656-1928 (fax)	___ School Nurse Martinsville Middle School 201 Brown Street Martinsville, VA 24112 276-403-5886 276-638-4140 (fax)
___ School Nurse Martinsville High School 351 Commonwealth Blvd. Martinsville, VA 24112 276-403-5870 276-403-5178 (fax)	___ School Nurse Clearview Early Childhood Center 800 Ainsley Street Martinsville, VA 24112 276-403-5800 276-403-5851 (fax)	

I give permission for the following agencies to share information about my child. (Attach additional sheets as needed.)

- Children's Medical Center Martinsville Pediatrics Piedmont Community Services National Counseling Group
 Eden Pediatrics Brenner Children's Hospital Family Preservation Services Martinsville Memorial Hospital

(Name of agency) *(Contact Information)*

(Name of agency) *(Contact Information)*

I want this information be exchanged for only eligibility determination for special education services and/or service coordination and planning.

This Consent will be effective **until**: _____

Signature(s): _____
(Consenting person or persons)

Date: _____

Person Explaining Form: _____
(Name) (Title) (Phone Number)

FOR SCHOOL USE ONLY: If this consent is revoked, partially or in its entirety, please check the box at the bottom of this form and fill out and attach a revocation form.

This consent has been revoked, effective _____