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CONFIDENTIAL
RELEASE OF INFORMATION

Child's Name: _____

Parent/Guardian: _____

I give permission for _____ and the Safe Schools/Healthy Students partner agencies identified below to exchange information about my child to effectively coordinate programs, services, and activities that are appropriate to meet the individual needs of my child.

- All SS/HS Partner Agencies
- My child's school district
- Child Care Coordinating Council
- Behavioral Health Services North
- Clinton County Mental Health
- Clinton County Sheriff's Office
- Clinton County Probation Dept
- Champlain Valley Family Center
- Essex County Mental Health
- Essex County Sheriff's Office
- Essex County Probation Dept
- Prevention Team

Purpose of disclosure (check all that apply):

- To provide ongoing communication
- To provide appropriate follow-up and ongoing support for my child
- Probation requirements
- Other: _____

This authorization will expire:

- At the conclusion of the *Communities of One* Safe Schools/Healthy Students project
- One year from this date

Signature of PARENT/LEGAL GUARDIAN	DATE

Signature of Witness
7/6/09:wm

Date