Citizens For Safe Schools
Authorization for Release and Exchange of Information

*Name of Mentee:*_____*Birthdate:*_____

I authorize and consent to the mutual exchange of information between the Mentors of Citizens for Safe Schools and the agencies or individuals indicated below for the purpose of supporting my health, safety and well being.

*School(s)*_____

Klamath Youth Development Center

*Other*_____

Information to be disclosed may include:

School Record
Family History
Medical Record
Psychological Evaluation
Court Record
Other _____

This consent is subject to revocation at any time, except to the extent that the program which is to make the disclosure has already taken action in reliance on it. If not previously revoked, this consent will terminate_____. If you prefer that any of the above information not be released to the mentoring program – please indicate by circling above those records you do NOT want disclosed.

I recognize the information named above may contain specifics that are protected by federal and state law, and I specifically consent to disclosure of such information.

_____ _____
Date *Signature of Student*

_____
Parent/Guardian

11/2007
Return to: CFSS/Mentors P.O. Box 243 Klamath Falls, OR 97601