K.E.Y.S. Academy

Knowledge Empowers Youth & Sobriety

Recovery High School

CONSENT TO OBTAIN/RELEASE INFORMATION

CMO / Therapist / Program Facility

I, ____ (student's name), authorize K.E.Y.S. Academy to release and/or receive the following information from my records:

Alcohol and Drug Screening Results

Assessment Results

Treatment Information

Program Participation

Follow-up Information

Billing/Finance Info

Other____

The purpose of the disclosure is to allow K.E.Y.S. Academy to collaborate and share information with other important treatment providers.

Name of Counselor: ____

Phone: ___________________________ Email Address: _________________________________

I understand that my records are protected and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I authorize the use or disclosure of my individual identifiable health information as described above and that this authorization is voluntary. I understand that I May revoke this consent at any time except to the extent that action has been taken reliance on it, and that in any event this consent expires automatically as at the beginning of the new school year.

______________________________________ ________________________________

Student Signature Date

_____________________________________ ________________________________

Parent Signature Date