Authorization for Exchange of Confidential Information

Student Information

Name:	
School:	BD:

Parent/Guardian Information

Contact Name:	Relationship:
Contact Address:	
Phone and Email:	

Your authorization is requested to exchange or submit information about your child. Please return this form to:

_____

I authorize Greater Victoria School District, to mutually exchange information with:

☐ _____

Information to be released: Student information (student history, diagnosis, assessments, student learning profile)

Purpose of the request: For school personnel to collaborate with a CYMH representative in developing strategies and suggestions to support the student.

In order to access Special Education services, the Ministry of Education requires school districts to have documentation to support that the student has been appropriately assessed and identified as meeting the criteria of the Special Education category.

This authorization takes effect the day that you sign it and expires one year from the date of the signature. You may revoke this authorization at any time.

☐ I consent to the exchange or release of the information

_____ _____

Signature Date

Revised: December 16, 2022 – CYMH Consultation & Collaboration Day Authorization

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