



Simply Hope Safe Teen Assessment Center  
1323 Oakley Ave Suite 20  
(208) 679-9401

### CONSENT FOR RELEASE OF SCHOOL INFORMATION

Student Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Address: \_\_\_\_\_

Student Telephone #: \_\_\_\_\_

School: \_\_\_\_\_ Grade: \_\_\_\_\_

Parent/Guardian Name: \_\_\_\_\_

Parent/Guardian Phone #: \_\_\_\_\_ Parent/Guardian Email: \_\_\_\_\_

Teacher Name and Email: \_\_\_\_\_

Teacher Name and Email: \_\_\_\_\_

I authorize (School district) \_\_\_\_\_ to release information regarding my child's education information. The Type and amount of information to be used or disclosed is as follows:

From (Date) \_\_\_\_\_ To (Date) \_\_\_\_\_

Academic performance     Achievements     Program Enrollment     IEP     504     BIP

Attendance     Open Communication     Other (Specify): \_\_\_\_\_

The purpose or need for this information is due to Youths enrollment in Simply Hope Family Outreach.

I understand that I have the right to revoke this authorization at any time. To revoke this authorization, I must submit a written revocation to Simply Hope Family Outreach.

I understand that information disclosed by (school district) \_\_\_\_\_ may be re-disclosed by Simply Hope Family Outreach to Grant Funders who may use the program information to support accountability and quality improvement.

This form will expire in 365 days unless otherwise specified. Unless otherwise revoked, the authorization revoked, the authorization will expire on the following dates, event or condition: \_\_\_\_\_

Signature of Student: \_\_\_\_\_

Signature of Parent/Guardian: \_\_\_\_\_

Relationship to Student: \_\_\_\_\_ Date: \_\_\_\_\_