AUTHORIZATION TO DISCLOSE INFORMATION
VISIONS OF TRUTH COMMUNITY DEVELOPMENT CORPORATION
Students Taking Responsibility in Valuing Education
STRIVE PROGRAM

Participant's Name: _____ Social Security No.: _____-_____-_____

Date of Birth: _____ Mental Health Diagnosis: Y/N _____

If yes, please list _____ Date Diagnosed: _____

Substance use or abuse: Y/N _____ If yes, list substances_____

Receiving Treatment: Y/N _____ If yes, list name and title of person providing treatment:

_____ Phone Number: _____

1. I authorize the disclosure of the above named individuals School record information as described below:
2. The following organization is authorized to make the disclosure:
   Name of School: _____
   Address: _____
3. The type of information to be disclosed is as follows:

Any and all school records, documents and things concerning the above named individual including, but not limited to:	
Report Cards	
Disciplinary Records	
Attendance Records	
Progress Reports	
Class Schedules	
Teacher Names	
Guidance Counselor Names	
Referrals	
IEP's	

4. This information may be disclosed to and used by the following organization:
   Name: STRIVE Address: 5910 Arden St. Portsmouth Virginia 23703 Phone Number:757-484-1266
5. I understand that I have the right to revoke this authorization at any time. I understand that I must do so in writing and present my written revocation to the director of the STRIVE program.
6. This authorization will expire on_____.

_____ _____
Signature Date

_____
If Signed by Legal Representative, relationship to the client:

_____
Witness Signature