



Student Name: _____

Grade: _____

Teacher: _____

Building of Attendance: CES CMS CHS

The Counseling Source: Consent for Referral and FERPA Release Form

The Counseling Source is a therapist-owned mental health agency and is independent of the Circleville City School District. The Counseling Source's staff is comprised of many mental certified mental health clinicians on site in the Circleville City School District. Our staff have been carefully trained in the provision of clinical services to children and how to deliver such services in school settings in such a way as to contribute to the student's overall success at school as well as at home and in the community. Services offered provide parents and guardians an opportunity to utilize additional counseling services for their child beyond those offered by the District's guidance counselor.

Circleville City Schools is requesting consent to refer your child to The Counseling Source and to release and permit access to personally identifiable information (PII) concerning your child's education to The Counseling Source. Should you have any questions regarding this referral, please contact the school guidance counselor or a building principal.

By signing this consent form, you are allowing Circleville City Schools to release and permit access to personally identifiable information (PII) concerning your child's education with The Counseling Source. Once The Counseling Source receives this consent form, they will contact you to gain further information. Under the Family Educational Rights and Privacy Act (FERPA) and Ohio Revised Code Section 3319.321, information cannot be shared with outside agencies without your authorization.

I, _____, individually and as parent and natural guardian of _____, **give/do not give** (circle one) my consent for the Circleville City School District Board of Education to release and permit access to personally identifiable information (PII) concerning the education of _____ which may be of assistance to requests, questions, and/or treatment provided to my child by The Counseling Source.

Primary Contact Number: _____

Secondary Contact Number: _____

Email Address: _____

PLEASE RETURN THIS FORM TO YOUR CHILD'S BUILDING OF ATTENDANCE