



LABBB Collaborative

*123 Cambridge Street
Burlington MA 01803*

INFORMED CONSENT AND RELEASE
FOR EXCHANGE OF INFORMATION
BETWEEN
LABBB COLLABORATIVE AND OUTSIDE AGENCIES, PROGRAMS and PROVIDERS

I, _____, hereby agree and give consent for the LABBB Collaborative
(Name of Parent/Guardian)

and the agencies, programs and providers listed below to release to and obtain from each other the student record, health and other confidential information and other Protected Health Information, as that term is defined in the Privacy Rule of the Health Insurance Portability and Accountability Act, of my child, _____.
(Name of Child)

include: _____
(List Agencies, Programs and/or Providers)

Further, I also give consent for the LABBB Collaborative and the above identified agencies, programs and/or providers to communicate with each other regarding my child. I have read this Informed Consent and Release and understand its terms. I sign it voluntarily and with full knowledge of its significance.

Parent/Legal Guardian's Signature

Date