

*To be translated into the student's home language*

**CAMBRIDGE PUBLIC SCHOOLS  
INFORMED CONSENT AND RELEASE FOR COUNSELING SERVICES**

I, \_\_\_\_\_, acknowledge that my child, \_\_\_\_\_,  
(Print Name of Parent/Guardian/Caregiver) (Print Child's Name)

has been recommended for counseling and/or outreach services. The reason(s) for the recommended counseling and/or outreach services are:

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I give consent for my child to be referred to the following counseling and/or outreach services (check all that are applicable):

Individual Counseling     Family Counseling     Group Counseling  
 Other \_\_\_\_\_  
(Specifically Describe)

I also give consent for the Cambridge Public Schools to release my child's 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 to the counseling and/or outreach services, and for my child to participate in these counseling and/or outreach services. Further, I also give consent for the Cambridge Public Schools to communicate with the following community agencies regarding my child:

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(List Community Agencies)

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I also agree and grant permission for these community agencies to release to the Cambridge Public Schools, including without limitation, my child's 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.

I understand that my participation in my child's counseling and/or outreach services is greatly appreciated and encouraged. I have read this Informed Consent and Release for Counseling and/or Outreach Services and understand its terms. I sign it voluntarily and with full knowledge of its significance, and understand that I may withdraw my consent at any time.

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Parent/Guardian/Caregiver's Signature

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Date