RELEASE OF INFORMATION

Participant Name: _____ **Date of Birth:** _____

I give _____permission to release information to, or obtain information about me from:

Agency or Name:	Seeds of Literacy
Street Address:	3104 W. 25th Street
City, State, Zip code:	Cleveland, Ohio 44109
Phone:	216-661-7950 Fax: 216-661-7952

The items to be released or received are solely for the purposes of coordinating academic and workforce development services on my behalf, and can include:

- ☐ Yes ☐ No Name
- ☐ Yes ☐ No Phone number
- ☐ Yes ☐ No Email Address
- ☐ Yes ☐ No Date of Birth
- ☐ Yes ☐ No Academic Attendance
- ☐ Yes ☐ No Other (specify): _____

- ☐ Yes ☐ No Academic Progress
- ☐ Yes ☐ No Workforce Program Enrollment
- ☐ Yes ☐ No Workforce Program Completion
- ☐ Yes ☐ No Employment Placement
- ☐ Yes ☐ No Enrollment in Postsecondary educ/ training

I understand that:

My information will be treated confidentially.
An original or a copy of this form is valid.
Information may be shared verbally, electronically, in person, or in writing.
I may revoke, or take back, my permission at any time.
If I choose to take back my permission I must do so in writing.
Unless I have revoked earlier, this release expires:

☐ Yes ☐ No 12 months from the date of my signature OR ☐ Yes ☐ No Date _____

Participant: _____ **Date:** _____

Guardian (if applicable):_____ **Date:** _____

Witness: _____ **Date:** _____

REVOCATION OF RELEASE OF INFORMATION

By signing below, I choose to revoke, or take back, my permission to release/obtain information effective from the date of my signature.

Participant: _____ **Date:** _____

Guardian (if applicable):_____ **Date:** _____

Witness: _____ **Date:** _____