

RED CLIFF BAND OF LAKE SUPERIOR CHIPPEWA INDIANS
TRIBAL SERVICE AND RELEASE OF INFORMATION FORM

Name: _____ Phone #: _____

Address: _____
Street or Box City State Zip

Social Security #: _____

I, the undersigned, understand that information may be exchanged between the following Divisions/Agencies I have authorized. Please check off those Divisions/Agencies that you agree to release information to.

YES NO

- | | | |
|-----|-----|--|
| ___ | ___ | Divisions of Administration |
| ___ | ___ | Division of Education, Employment and Training |
| ___ | ___ | Division of Family Services |
| ___ | ___ | Division of Health |
| ___ | ___ | Division of Human Services |
| ___ | ___ | Support Services |
| ___ | ___ | Other Agencies/Institutions (Schools, Vocational/Technical or similarly related facilities in the best interest of the client.) |

Name of School

I give permission to release information to and between the above Divisions/Agencies checked off, for the purpose of determining potential eligibility. I can withdraw this permission at any time, from any or all Divisions/Agencies listed. I will do so in writing. This withdrawal of permission will go into effect immediately after it is recieved by a Tribal staff member from any of the above listed Divisions/Agencies.

Signature

Date

Department Head

Date