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