



**AUTHORIZATION TO RELEASE INFORMATION BETWEEN AGENCIES
and
AGREEMENT FOR NON-DUPLICATION OF SERVICES**

STUDENT INFORMATION:

Student Name: _____ Student ID: _____

Address: _____ City: _____ Zip: _____

Phone: _____ Email: _____

I understand the CARE program provides special program and activities that are over, above and beyond those provided to EOPS and students served by other programs in the district. Furthermore, grants and services awarded to me by the CARE program shall not duplicate or supplant any federal, state or institutional aid to which I am entitled.

I authorize release of information regarding my eligibility for services between the College, the College District, the Chancellor's Office, Shasta/Tehama/Trinity Department of Social Services, Shasta County Office of Education, Early Head Start, and Northern Valley Catholic Social Services.

I hereby affirm that under the penalty of perjury, that all information given is true and complete to the best of my knowledge. I also realize that any false statement may be cause for denial, reduction, withdrawal, and/or repayment of any monetary services I may receive from the CARE program.

Student Signature

Date

