



Special Education Local Plan Area

CONSENT TO RELEASE OR EXCHANGE INFORMATION

NAME OF STUDENT _____ BIRTHDATE _____

DISTRICT/SCHOOL: _____

Written parental consent shall be obtained before personally identifiable information is disclosed in writing or orally to anyone other than authorized employees specified by the school district. You need to know that:

- You choose which agencies shall exchange information.
- You may refuse to sign this exchange form.
- Information about your child and family is strictly confidential. Your child's school maintains records specifying the source of the information, the date and purpose of any disclosure, and with whom information was shared.
- These records will help in evaluation assessment and IEP development of your child.
- You have the right to review records.
- Your rights are preserved under: Title 34 Code of Federal Regulations; Family Education Rights Privacy Act of 1974, Title 20 of the United States Code, Section 1232 (g), Title 34 Code of Federal Regulations, Section 99.
- This consent is good for one year unless you withdraw your consent before that time.

I give permission for the above named Local Education Agency to exchange information relevant to my child's educational and related service needs with the following agency/agencies. Please **initial** the box(es) below to permit the exchange of information about your child with the specific agency/agencies.

- | | |
|---|---|
| <input type="checkbox"/> School District: _____ | <input type="checkbox"/> Occupational Therapist: _____ |
| <input type="checkbox"/> Audiologist: _____ | <input type="checkbox"/> Other Medical Specialist: _____ |
| <input type="checkbox"/> California Children's Services: _____ | <input type="checkbox"/> Primary Care Physician/Clinic: _____ |
| <input type="checkbox"/> County Offices of Education: _____ | <input type="checkbox"/> Psychologist/Psychiatrist: _____ |
| <input type="checkbox"/> Behavioral Health and Recovery Services: _____ | <input type="checkbox"/> Public Health Nursing: _____ |
| <input type="checkbox"/> Dept. of Rehabilitation: _____ | <input type="checkbox"/> Regional Center: _____ |
| <input type="checkbox"/> Family Resource Centers: _____ | <input type="checkbox"/> Speech Therapist: _____ |
| <input type="checkbox"/> Human/Social Services Dept: _____ | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Infant Development Program: _____ | <input type="checkbox"/> Other: _____ |

A photocopy of this form shall be as valid as the original. I understand that I am to receive a copy of this authorization.

Parent/Guardian: _____ Date: _____

Parent/Guardian: _____ Date: _____

Please return information to:

District Name: _____

Address: _____

Attention: _____

Phone: _____

Fax: _____