PARENT CONSENT FOR RELEASE OF INFORMATION

Student's Name: ______________________________________ Date of Birth: ___________________________

I authorize the following individual or organization to disclose the above named individual's health /education information as described below:

Information to be released and received by

____
Name of Professional or Agency

____
Address

____
Phone

____
Fax

Information to be released and received by:

Santa Barbara Unified School District ____________
Name of Professional or Agency

720 Santa Barbara Street, Santa Barbara, CA 93101
Address

(805) 963-4338 _____________________________
Phone

____
School Name

____
School Address

In signing I confirm that information and communication may be exchanged between the parties regarding the following:

- ☐ Educational
- ☐ Psychological
- ☐ Medical
- ☐ Developmental
- ☐ Other: ____

I request that the information released be used for the following purposes only:
☐ Educational Assessment ☐ Educational Planning ☐ Other: ________________________________

I understand that I have the right to revoke this authorization in writing. Written revocation is effective upon receipt, but will not apply to information provided prior to written revocation. I further understand that health information may be redisclosed to necessary school personnel within the receiving agency. The confidentiality of the information when released is protected as a student record under the Family Educational Rights and Privacy Act (FERPA). This agreement is effective for one year from the date of signature or until ___________________. I understand I have a right to receive a copy of this authorization.

Any information received by the public school must, by law, be included in the student's records. A copy of this authorization is valid as an original.

________________________________ ________________________________ _________________________
Signature Relationship to Student Date