



Santa Barbara Unified School District

720 Santa Barbara Street, Santa Barbara, CA 93101 Phone 805-963-4338, TDD 805-966-7734, Fax 805-963-1992
www.sbsd.k12.org

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:

Information to be released and received by:

<p>_____ Name of Professional or Agency</p> <p>_____ Address</p> <p>_____ Phone</p> <p>_____ Fax</p>	<p>Santa Barbara Unified School District _____ Name of Professional or Agency</p> <p>720 Santa Barbara Street, Santa Barbara, CA 93101 _____ Address</p> <p>(805) 963-4331 _____ Phone</p> <p>_____ School Name</p> <p>_____ School Address</p>
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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