APPENDIX A

Humboldt-Del Norte
SELPA
Special Education Local Plan Area

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CONSENT TO RELEASE OR EXCHANGE INFORMATION

CHILD'S NAME: ______________________ **DATE OF BIRTH:** ______________

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.
- 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 ______________________________ to exchange information relevant to my child's education needs with the following agency/agencies/individual(s). Please initial the box(es) below to permit the exchange of information about your child with the specified agency/agencies/individual(s).

(Space after agency name may be used for phone and/or fax information.)

☐ Audiologist: ____________________
☐ California Children's Services: ____________________
☐ Community Child Care Resources: ____________________
☐ County Offices of Education: ____________________
☐ Dept. of Mental Health: ____________________
☐ Dept. of Rehabilitation: ____________________
☐ Family Resource Centers: ____________________
☐ Human/Social Services Dept.: ____________________
☐ Infant Development Program: ____________________
☐ OT and/or PT: ____________________
☐ Other Medical Specialist: ____________________
☐ Primary Care Physician/Clinic: ____________________
☐ Public Health Nursing: ____________________
☐ Regional Center: ____________________
☐ Speech Therapist: ____________________
☐ Other: ____________________
☐ Other: ____________________
☐ 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: ____________________

Form #