San Francisco Unified School District
Authorization for Release of Confidential Information

Student's Name: _____ **Date of Birth:** ____/_____/____

School/Dept: _____ **Address:** _____

Contact Person: _____ **Title:** _____ **Telephone:** _____

I authorize the <u>exchange</u> of information described below between the San Francisco Unified School District and the following agency(s) and/or individual(s):

- ❑ Healthcare provider(s)_____ (name)
- ❑ Agency(s) _____ (name)
- ❑ Parent/ legal guardian (if minor consented to care) _____ (name)
- ❑ Other _____

This authorization applies to the following information: *(check each line that applies)*

_____ Educational Data/IEP _____ Social/Developmental _____ Psychological

_____ Vision _____ Speech/Language _____ Audiological

_____ Medical _____ Other _____

Expiration: This authorization expires (date or event): _____

Restrictions: Providers who receive this information may not release it to someone else unless another authorization form is signed.

Your Rights: You may refuse to sign this form. You may cancel it at any time by informing the San Francisco Unified School District in writing. If you cancel your permission to allow the release of information about you/your child, it will go into effect immediately (unless someone already released information). You have a right to receive a copy of this Authorization.

Signature _____ **Date** _____

Indicate relationship to student: ❑ parent ❑ legal guardian: _____

See other side for Screening and Assessment Use