San Diego Unified
SCHOOL DISTRICT

SPECIAL EDUCATION DIVISION
4100 Normal Street, Annex 6
San Diego, CA 92103

RELEASE OF INFORMATION

Dear Parent/Guardian:

Your signature is required on this form in order to obtain information from the individual/private institution name below. Please keep one copy of the form for your records and return one signed copy to the address listed below.

TO: _____
Name of Individual and or Private School

_____
Address of Individual and or Private School

_____
City/State/Zip Code of Individual and or Private School

I hereby give the San Diego Unified School District my consent to obtain and/or exchange with the individual or private institution named above ☐ educational and/or ☐ psychological information relative to my child.

_____ _____
Student's Last Name, First Name, MI Birth Date

I understand that San Diego Unified School District will protect this information as prescribed by the Family Educational Rights and Privacy Act (FERPA) and that the information becomes part of the student's educational record. The information will be shared with individuals working at or with the school district for the purpose of providing a free appropriate public education (FAPE).

_____
Signature of Parent/Guardian Date

This release is effective immediately and shall remain in effect for one year from the date of signature. The student's parent or legal guardian will have the right to inspect and review the record and to receive a copy of the information it contains.

(For Office Use Only)
Please send the information checked above to: **SAN DIEGO UNIFIED SCHOOL DISTRICT**

_____ _____
SDUSD Name/Position Phone/Email

_____
SDUSD School Name

_____
Address

_____
City/State/Zip Code

If you have questions or need additional information, please contact Parentally Place Private School Services at PPPSSAdmin@sandi.net.

San Diego Unified
SCHOOL DISTRICT

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4100 Normal Street, Annex 6
San Diego, CA 92103

RELEASE OF INFORMATION

Only complete if you reside outside of San Diego Unified School District Boundaries

Dear Parent/Guardian:

Your signature is required on this form in order to exchange information to/from your District of Residence. Please keep one copy of the form for your records and return one signed copy to the address listed below.

TO: _____
Name of District of Residence

_____
Address of District of Residence

_____
City/State/Zip Code of District of Residence

I hereby give the San Diego Unified School District my consent to obtain and/or exchange with the District of Residence named above ☐ educational and/or ☐ psychological information relative to my child.

_____ _____
Student's Last Name, First Name, MI Birth Date

I understand that San Diego Unified School District will protect this information as prescribed by the Family Educational Rights and Privacy Act (FERPA) and that the information becomes part of the student's educational record. The information will be shared with individuals working at or with the school district for the purpose of providing a free appropriate public education (FAPE).

_____ _____
Signature of Parent/Guardian Date

This release is effective immediately and shall remain in effect for one year from the date of signature. The student's parent or legal guardian will have the right to inspect and review the record and to receive a copy of the information it contains.

(For Office Use Only)
Please send the information checked above to: **SAN DIEGO UNIFIED SCHOOL DISTRICT**

_____ _____
SDUSD Name/Position Phone/Email

_____
SDUSD School Name

_____
Address

_____
City/State/Zip Code

If you have questions or need additional information, please contact Parentally Place Private School Services at PPPSSAdmin@sandi.net.

AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION TO AND FROM SCHOOLS

Completion of this document authorizes the disclosure and/or use of individually identifiable health information, as set forth below, consistent with California and Federal laws (e.g., HIPAA) concerning the privacy of such information. Failure to provide all information requested may invalidate this authorization.

USE AND DISCLOSURE INFORMATION:

Patient/Student Name: _____
Last **First** **MI** **Date of Birth**

I, the undersigned, do hereby authorize (name of health care provider, health plan and/or agency):

_____ _____

to provide health information from the above-named child's medical record to and from:

San Diego Unified School District | 4100 Normal St. San Diego,CA 92103

School to Which Disclosure is Made | **Address / City and State / Zip Code**

_____ _____

Contact Person at School District | **Telephone and Fax Number**

Disclosure of health information is required for the following purpose: Special Education Assessment

Requested information shall be limited to the following:

☐ All minimum necessary health information; **or** ☐ Disease-specific information as described: _____

DURATION:

This authorization shall become effective immediately and shall remain in effect until _____ **(enter date)** or for one year from the date of signature, if no date entered.

RESTRICTIONS:

California law prohibits the Requestor from making further disclosure of my health information unless the Requestor obtains another authorization form from me or unless such disclosure is specifically required or permitted by law.

PARENT/GUARDIAN RIGHTS:

I understand that I have the following rights with respect to this Authorization: I may revoke this Authorization at any time. My revocation must be in writing, signed by me or on my behalf, and delivered to the health care agencies/persons listed above. My revocation will be effective upon receipt, but will not be effective to the extent that the Requestor or others have acted in reliance to this Authorization.

STUDENT RIGHTS:

Students between the ages of 12 and 18 years must sign this form in order to approve the disclosure of information relating to mental health and family planning issues.

RE-DISCLOSURE:

I understand that the Requestor (School District) will protect this information as prescribed by the Family Educational Rights and Privacy Act (FERPA) and that the information becomes part of the student's educational record. The information will be shared with individuals working at or with the School District for the purpose of providing safe, appropriate, and least restrictive educational settings and school health services and programs.

I have a right to receive a copy of this Authorization. Signing this Authorization may be required in order for this student to obtain appropriate services in the educational setting.

APPROVAL:

Parent Printed Name	Parent Signature	Date
Relationship to Patient/Student	Area Code and Telephone Number	
Student Printed Name	Student Signature	Date