



Parent Permission for Release of Information

Student Information:	
Student Name: First, Middle, Last	
DOB/Age:	
Current School/Grade:	
Current Program:	

I hereby consent to, request, and authorize any and all persons or entities listed below to exchange information including any or all social, psychological, medical, speech/language and educational information and records with the Laguna Beach Unified School District regarding the above named person:

1	Name:	Phone:	Fax:	Email:
	Address:	City:	State:	Zip:

2	Name:	Phone:	Fax:	Email:
	Address:	City:	State:	Zip:

3	Name:	Phone:	Fax:	Email:
	Address:	City:	State:	Zip:

4	Name:	Phone:	Fax:	Email:
	Address:	City:	State:	Zip:

5	Name:	Phone:	Fax:	Email:
	Address:	City:	State:	Zip:

6	Name:	Phone:	Fax:	Email:
	Address:	City:	State:	Zip:

Please email, mail, or fax requested information to Laguna Beach Unified School District as follows:

Name:	Phone:	Fax:	Email:
Address:	City:	State:	Zip:

This authorization shall remain in effect until revocation in writing has been delivered to the school district.

Parent/Guardian Signature:	Date:	Relationship to Student:
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Date Received by District: _____