

Menlo Park City School District, Student Services Department

181 Encinal Avenue

Atherton, CA 94027

(650) 321-7140 x5610 Fax: (650) 292-2200

Authorization for Release and Exchange of Confidential Information and/or Records

This consent authorizes the gathering, exchange and release of information and/or records for the purpose of providing effective special education services for your child. A photocopy of this document is valid as the original.

I, _____, the parent/legal guardian of _____ hereby authorize the release, sharing and exchange of confidential information and/or records regarding my child to the Menlo Park City School District.

For the purpose of providing, verifying and coordinating services, place your initials in front of the agencies listed below that may provide information to the Menlo Park City School District.

County Health Agencies

- ___ California Children Services
- ___ County Mental Health
- ___ Public Health

Other Health/Disabilities Agencies

- ___ Golden Gate Regional Center (GGRC)
- ___ Primary Care Provider or ___ Other Provider: _____
Name: _____
Address: _____
Phone: _____
- ___ Primary Care Provider or ___ Other Provider: _____
Name: _____
Address: _____
Phone: _____

County Criminal Justice

- ___ Probation Department
- ___ Sheriff's Department

County Social Services

- ___ Child Protective Services

Other:

- ___ _____
- ___ _____

I hereby authorize the agencies initialed above to exchange the following information through verbal and or written communication and/or electronic transmissions. (i.e., Fax, E-mail) as selected by initialization:

- ___ Information contained in the special education confidential file
- ___ Information contained in the school cumulative file
- ___ Mental health diagnoses, assessment, evaluation, progress
- ___ Medical and/or disability diagnoses, assessment, evaluation, progress
- ___ Probation contracts
- ___ Court orders, reports and case plans
- ___ Related medical, mental health, developmental, education, psychosocial histories
- ___ Other: _____

I understand I may receive a copy of this document if requested. Copy received Yes No

I want my child's records to be released. I realize that this is a required consent and that I must voluntarily and knowingly sign this authorization BEFORE any records or information can be released. I may refuse to sign and in that event the records cannot and will not be released. This authorization shall remain in effect for one year from the date of signature. It may be rescinded at any time via written notification to the Menlo Park City School District.

Parent/Legal Guardian/Educational Representative

Date