MEMBERS OF THE BOARD

WENDY SIMS-MOTEN, PRESIDENT GABE ESCOBEDO ROSE MUÑOZ WILLIAM BANNING SUNITA BEALL



Main Office 720 Santa Barbara Street Santa Barbara, CA 93101 Phone: 805. 963.4338 | TDD: 805.963.7734

DR. HILDA MALDONADOSuperintendent

Parent/Guardian Consent for Release of Information

Student Name:		Date of Birth:
Grade:	School:	ID:
professionals listed b professionals in acco	pelow as described. The i	formation to be shared between the agencies and/or information received shall be reviewed only by appropriate family educational rights and privacy act). I authorize the
Name of Person or Agency		Santa Barbara Unified School District
Address		720 Santa Barbara Street Santa Barbara Ca 93101
Phone		(805) 963-4331 Ext
Fax		
Email		
Contact person		
School Name		
ollowing:	ecords and or information / Mental Health records/inf sical health records inform	

The Santa Barbara Unified School District (SBUnified) prohibits discrimination, harassment, intimidation and bullying in educational programs, activities, or employment on the basis of actual or perceived ancestry, age, color, disability, gender, gender identity, gender expression, nationality, race or ethnicity, immigration status, religious beliefs or customs, sexual orientation, parental, pregnancy, family or marital status, military status or association with a person or a group with one or more of these actual or perceived characteristics.

SBUnified requires that school personnel take immediate steps to intervene when safe to do so when he or she witnesses an act of discrimination, harassment, intimidation, or bullying.

use and disclos I initial next to t Drug/Alc HIV/AID: Behavior	
☐ Educatio	use the released records only for the following purpose(s): nal Assessment
	authorization shall become effective immediately and shall remain in effect for one year from the date (enter a specific date) :
Your rights:	
2. 3. 4.	understand that I have the right to revoke (withdraw) this authorization at any time by submitting a written request to the school district. This withdrawal will be effective upon receipt, but will not apply o information provided prior to the written revocation. understand that I have a right to receive a copy of this release upon my request. Information disclosed following receipt of this authorization could be disclosed from the recipient and night no longer be protected by federal confidentiality law (HIPPA); however, California law prohibits the person receiving the health information from making further disclosure of the information unless another authorization for such disclosure is obtained from me or unless such disclosure is specifically equired or permitted by law. The confidentiality of the information when released is protected as a student record under the Family Educational Rights and Privacy Act (FERPA). This agreement is effective for one year from the date of signature or until I understand I have a right to receive a copy of this authorization. Any information received by the public school must, by law, be included in the student's records. A copy of this authorization is valid as an original.
	release of information, I agree that I am providing permission for verbal or written records and or e released, disclosed and shared between the two agencies/professionals listed above.
Signature	Relationship to Student Date
Printed name Form # 1/2024	