



San Mateo County

Special Education Local Plan Area

CONSENT TO RELEASE OR EXCHANGE INFORMATION

NAME OF STUDENT _____ DOB _____

DISTRICT Jefferson Union High School District SCHOOL _____

PARENT/GUARDIAN RIGHTS

Written parental consent shall be obtained before personally identified information is disclosed in writing or orally to anyone other than authorized employees specified by the school district. You have the right to:

- You choose which agencies shall exchange information.
You may refuse to sign this exchange form.
Information about your child, and family is strictly confidential.
Your child's school maintains records specifying the source of the information, the date, and purpose of any disclosure and with whom the information was shared.
These records will help in evaluation assessment and IEP development of your child.
You have the right to review records.
You have the right to receive a copy of this authorization.
Your rights are preserved under: Title 34 Code of Federal Regulations: Family Education Rights Privacy Act of 1974, Title 20 of the United States Code, Section 1232(g), Title 34 Code of Federal Regulations, Section 99.
This consent is good for one year unless you withdraw your consent before that time.

ATHORIZATION

I give permission for the above named Local Education Agency to exchange information relevant to my child's educational and related services needs with the following agency/agencies. Please check the box(es) below, and include the provider's name and contact information to permit the exchange of information about your child with the specified agency/agencies:

Table with 2 columns and 8 rows for agency selection. Rows include: Audiologist, Pediatrician, California Children's Services, Primary Care Physician, County Offices of Education, Psychiatrist/Phycologist, Dept. of Rehabilitation, Regional Center, Family Resources Center, School District, Human/Social Services Dept, Speech Therapist, Infant Development Prgm, Other, Occupational Therapist, Other.

(A photocopy/PDF/faxed version of this form shall be as valid as the original)

Further document(s) attached

Continue to the signature page



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RE-DISCLOSURE

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

I understand that signing this Authorization may be necessary in order for my student/child to obtain appropriate services and support in the educational setting.

Parent/Guardian Date

Parent/Guardian Date

Return Information

**ATTN:
DISTRICT NURSE; Stacey Burnett BSN, RN PHN.
Jefferson Union High School District
699 Serramonte Blvd. Daly City, CA 94015
Direct: 650-550-7864
Email: sburnett@juhsd.net
Fax: 550-7888**