**Menlo Park City School District, Student Services Department**
**181 Encinal Avenue**
**Atherton, CA 94027**
**(650) 321-7140 x5610 Fax: (650) 328-1275**

## 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