San Diego County
North Coastal Consortium
For Special Education

Authorization For Exchange Of Information

District _____

Date _____

Student _____ _____ DOB _____
Last First

Address _____ _____ _____ _____
City State Zip

Phone _____ _____ _____
Home Work Case Manager

I hereby authorize the exchange of records between the following:

Agency:

_____

_____

_____

_____

_____

_____

School District:

_____

_____

_____

_____

_____

Attn.: _____

Please send records to the above stated school district.

1. Requested records will be used for the following purpose(s):

_____

_____

_____

_____

_____

2. This authorization shall remain for one year from the date of signature unless revoked in writing by the pupil or the pupil's parent, guardian or conservator.

I hereby consent to the release of :

☐ Audiological reports ☐ IFSP ☐ Medical reports ☐ PT/OT evaluation, progress reports
☐ Educational reports ☐ IPP ☐ Pychological/psychiatric reports ☐ Other _____

_____ _____
Person giving consent Date

Indicate relationship to pupil: ☐ Guardian ☐ Parent ☐ Self ☐ Surrogate