SONOMA COUNTY SELPA

CONSENT TO RELEASE OR EXCHANGE INFORMATION

CHILD'S NAME: _____ **DATE OF BIRTH:** _____

DISTRICT/SCHOOL: _____

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

- 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 information was shared.
- These records will help in evaluation, assessment and IEP development for your child.
- You have the right to review records.
- 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.

I give permission for SCOE DHH Program to exchange information relevant to my child's educational needs with the following agency/agencies. Please initial the box(es) below to permit the exchange of information about your child with the specified agency/agencies.

(Space after agency name may be used for phone and/or fax information.)

- ☒ Audiologist: _____
- ☐ California Children's Services: _____
- ☐ Community Child Care Resources: _____
- ☐ County Offices of Education: _____
- ☐ Dept. of Mental Health: _____
- ☐ Dept. of Rehabilitation: _____
- ☐ Family Resource Centers: _____
- ☐ Human/Social Services Dept: _____
- ☐ Infant Development Program: _____
- ☐ OT and/or PT: _____
- ☒ Other Medical Specialist: ENT
- ☐ Primary Care Physician/Clinic: _____
- ☐ Public Health Nursing: _____
- ☐ Regional Center: _____
- ☐ Speech Therapist: _____
- ☐ Other: _____
- ☐ Other: _____
- ☐ Other: _____

A photocopy of this form shall be as valid as the original. I understand that I am to receive a copy of this authorization.

Parent/Guardian: _____ Date: _____

Parent/Guardian: _____ Date: _____

Please return information to:

District Name: Sonoma County Office of Education

Address: 5340 Skylane Blvd., Santa Rosa, CA 95403

Attention: Neisha Smith

Phone: 707-524-2700 Fax: 707-578-3156