



SVUSD Permission for Release and Exchange of Information

Student Information			
_____	_____		
Last Name, First Name MI	ID Number		
_____	_____	_____	_____
School	Grade	DOB	Age

I authorize the following individual and/or organization to exchange information with the Saddleback Valley Unified School District regarding the above-named individual. The information collected will be handled confidentially, in compliance with all federal and state law, regulations, and SVUSD policies. This authorization shall remain in effect until revocation in writing has been delivered to the school district. Revocation may occur at any time.

Individual or Organization Information	
Name: _____	Email Address: _____
Address: _____	
Phone Number: _____	Fax Number: _____
Type of Information to be Exchanged (check all that apply):	
<input type="checkbox"/> Conduct Observation of Student	<input type="checkbox"/> Educational Records
<input type="checkbox"/> Mental Health/Psychological/Psychiatric Records	<input type="checkbox"/> Medical Records
<input type="checkbox"/> Psychoeducational/Speech and Language/Other Assessment Records	
<input type="checkbox"/> All Records	<input type="checkbox"/> Other: _____

Consent (please check one):

Yes, I give my permission.

No, I do not give my permission.

Parent/Guardian/Adult Student Signature

Relationship to Student

Date

For District Use Only:

Date received by District: _____
10/2021

Date revoked: _____

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