POWAY UNIFIED SCHOOL DISTRICT

Special Education/Health Services
15250 Avenue of Science, San Diego CA 92128

AUTHORIZATION FOR RELEASE/EXCHANGE OF INFORMATION

I hereby request and authorize you to release/exchange any relevant medical, social, psychological, and/or test information you may have or may receive pertaining to:

Student's Name:	D.O.B.	School:

The disclosure of this information is required for the following purpose(s):

Educational Planning: ____

____

To:	From:
Agency Name:	Agency Name:
Attention:	Attention:
Address:	Address:
City, State, Zip:	City, State, Zip:
Phone and Fax:	Phone and Fax:

I understand that this consent is valid for one (1) year from the date of signing and that I may revoke this consent, at any time, by notification in writing to either of the named agencies. This revocation shall apply to both agencies.

____
Parent/Guardian/Surrogate Signature

____
Relationship to Student

____
Date