

San Diego City Schools  
Institute for Learning  
Counseling and Guidance

RELEASE OF INFORMATION

To: \_\_\_\_\_  
Name of Service Provider Phone No. Fax No.  
\_\_\_\_\_  
Address  
\_\_\_\_\_  
City/State/ZIP Code

I hereby give the San Diego Unified School District my consent to obtain and/or exchange with the service provider named above  
 educational,  medical,  psychological information relative to my child,

\_\_\_\_\_  
Student's Name (Last, First, Middle Initial) Birth Date/ID Number School  
\_\_\_\_\_

(Please note: Any information received will become a part of the student's records; the student's parent or legal guardian will have the right to inspect and review the record and to receive a copy of information it contains.)

Please send the information checked above to:

\_\_\_\_\_  
Name  
\_\_\_\_\_  
School Phone No. Fax No.  
\_\_\_\_\_  
Address  
\_\_\_\_\_  
City/State/ZIP Code

Dear Parent/Guardian: Please sign this form so we may request /exchange information with the service provider named above.

Signature \_\_\_\_\_ Date \_\_\_\_\_  
 Parent  Guardian

Name: \_\_\_\_\_  
Please print

Distribution: Original : School Records, Canary Copy: Service Provider, Pink Copy: Counselor, Gold Copy: Parent/Guardian.