ADVOCACY 4 SD

AUTHORIZATION FOR THE USE AND/OR DISCLOSURE OF INFORMATION

Student's Name_____ **ID #**_____**Date of Birth** _____

Student's Address_____

***Parent(s) Names**_____

Phone/Cell Number _____ **Email** _____

*** I authorize the following individual or organization to disclose the above named students' educational information as described below:**

Individual/Organization DISCLOSING Information	Individual/Organization RECEIVING Information
Disclosing District/ School _____	Receiving Party: **ADVOCACY 4 SD**
Address_____	Address: **7467 Mission Gorge Rd. #110**
City, State, Zip Code_____	City, State, Zip Code **Santee, CA. 92071**
Telephone_____	Telephone **619-977-3148**
ATTN:_____	ATTN: **Dr. Andrea L. Katz**

Duration: This authorization shall become effective immediately and shall remain in effect for one year from the date of Parent/Guardian signature.

Revocation: I understand that I have the right to revoke this authorization, IN WRITING, at any time by sending such written notification to the DISCLOSING organization.

Specify Records: Educational Records (Special Ed. Documents /Psycho-educational Assessments, SLP, OT, APE, AT Assessments and Data, IEPs, Progress Reports and Data, Behavior Intervention Plans, Behavior Records, Report Cards, District/State Assessments; **Mental Health/Counseling Records**

* I request that the information released pursuant to this authorization be used for the following purposes only: **Educational Planning,**_____

A copy of the authorization is as valid as an original.

I understand that I have a right to receive a copy of this authorization for my records.

Parent/Guardian. Signature _____

Relationship to Student_____ Date Signed_____