

Capistrano Unified School District  
San Juan Capistrano, California

Parent Permission for Release of Information

Student's Name \_\_\_\_\_ D.O.B. \_\_\_\_\_ Date \_\_\_\_\_  
Address \_\_\_\_\_ Phone \_\_\_\_\_  
City \_\_\_\_\_ Zip \_\_\_\_\_ School \_\_\_\_\_

I hereby consent to, request, and authorize any and all persons or entities listed below to release any or all medical, social, psychological, speech/language or educational information regarding the above named person:

from the Capistrano Unified School District to the following agencies for inclusion in their records.

1. Name \_\_\_\_\_ Phone \_\_\_\_\_ Fax \_\_\_\_\_  
Address \_\_\_\_\_ City/State \_\_\_\_\_ Zip \_\_\_\_\_
2. Name \_\_\_\_\_ Phone \_\_\_\_\_ Fax \_\_\_\_\_  
Address \_\_\_\_\_ City/State \_\_\_\_\_ Zip \_\_\_\_\_
3. Name \_\_\_\_\_ Phone \_\_\_\_\_ Fax \_\_\_\_\_  
Address \_\_\_\_\_ City/State \_\_\_\_\_ Zip \_\_\_\_\_
4. Name \_\_\_\_\_ Phone \_\_\_\_\_ Fax \_\_\_\_\_  
Address \_\_\_\_\_ City/State \_\_\_\_\_ Zip \_\_\_\_\_

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from the following agencies to the Capistrano Unified School District, for inclusion in its records:

1. Name \_\_\_\_\_ Phone \_\_\_\_\_ Fax \_\_\_\_\_  
Address \_\_\_\_\_ City/State \_\_\_\_\_ Zip \_\_\_\_\_
2. Name \_\_\_\_\_ Phone \_\_\_\_\_ Fax \_\_\_\_\_  
Address \_\_\_\_\_ City/State \_\_\_\_\_ Zip \_\_\_\_\_
3. Name \_\_\_\_\_ Phone \_\_\_\_\_ Fax \_\_\_\_\_  
Address \_\_\_\_\_ City/state \_\_\_\_\_ Zip \_\_\_\_\_
4. Name \_\_\_\_\_ Phone \_\_\_\_\_ Fax \_\_\_\_\_  
Address \_\_\_\_\_ City/State \_\_\_\_\_ Zip \_\_\_\_\_

**Please mail or fax to:**

Name \_\_\_\_\_ Phone \_\_\_\_\_ Fax \_\_\_\_\_  
Address \_\_\_\_\_ City/State \_\_\_\_\_ Zip \_\_\_\_\_

A photocopy/facsimile of this document is as valid as the original.

This authorization shall remain effective until revocation in writing has been delivered to said school district.

Signature \_\_\_\_\_ Date \_\_\_\_\_ Relationship to student \_\_\_\_\_