Santa Clarita Valley SELPA

Mutual Exchange of Information Authorization

This authorization is limited to the reports / tests listed: 	☐ Education Assessment (specify)_____ ☐ Behavioral Reports (specify)_____ ☐ Psychological Tests (specify)_____ ☐ Vocational Tests (specify)_____ ☐ Medical Tests (specify) _____ ☐ Developmental Tests (specify)_____ ☐ Other (specify)_____

Student Name:	☐ Male ☐ Female	**Birth Date:**
Address:	**City, State, Zip:**	**Home Phone:**

The information specified above may be mutually exchanged between:

School District:	**Name of Business:**
Address:	**Address:**
City, State, Zip:	**City, State, Zip:**
Phone:	**Phone:**
Fax:	**Fax:**
Contact Person:	**Contact Person:**

This authorization shall become effective on the date signed and remain in effect for one calendar year. Authorization is subject to revocation by the undersigned at any time except to the extent that action has already been taken.

I understand that the receiver may not further use or disclose the medical information unless another authorization is obtained from me, or unless such use or disclosure is specifically required or permitted by law.

I understand that I have the right to receive a copy of this authorization if I so request.

I authorize the mutual exchange of the above specified information.

Authorized Signature - Parent/Guardian	**Print Name/Title**	**Date**
Complete Address	**City, State**	**Zip Code**
Primary Phone	**Cell Phone**	**Additional Phone**