

LOS ANGELES UNIFIED SCHOOL DISTRICT  
DIVISION OF SPECIAL EDUCATION  
DISTRICT OFFICE OF TRANSITION SERVICES

Consent to Release Confidential Student Information

Student's Name: \_\_\_\_\_

Student's Date of Birth: \_\_\_\_\_ Name of School: \_\_\_\_\_

CHECK ONE:

I am the \_\_\_\_\_ of the above named student, and non-emancipated student under the age of 18. I hereby consent to the release of confidential student information relating to this student.

I am the emancipated student or student over 18 years of age. I hereby consent to the release of my confidential student information.

I hereby give you permission to release the following information:

- Educational Records
- Speech and Language
- Other \_\_\_\_\_
- Individualized Education Plan
- Psychological Records

Purpose of Release:

\_\_\_\_\_

This information is to be sent to:

\_\_\_\_\_  
Name or Agency Position

\_\_\_\_\_  
Street Address

\_\_\_\_\_  
City State Zip Code

This authorization shall be valid \_\_\_\_\_ through \_\_\_\_\_  
Beginning date Ending date  
unless revoked earlier.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
Parent/Legal Guardian Student