Authorization to Disclose or Receive Information

Student's Name ____ D.O.B. _________

Agency/Service Provider____

Agency/Service Provider's Address____

City____________________________ State ___________ Zip ___________

Agency/Service Provider's telephone _________________________________

Agency/Service Provider's email address ____

Parent Authorization

I authorize the above listed agency/service provider to release my child's records and information pertaining to mental or physical condition, services and/or treatment to Pasadena Christian School.

I authorize Pasadena Christian School to use the information for my child's educational planning and student support. I understand that Pasadena Christian may not further use or disclose the information unless another authorization is obtained from me or unless such use or disclosure is specifically required or permitted by law.

This authorization shall become effective immediately and shall remain in effect for one calendar year.

I understand that I will receive a copy of this authorization for my records. A copy of this authorization is as valid as the original.

Parent Signature ____*Date:* ______________

TO THE AGENCY/SERVICE PROVIDER

The above named student is enrolled at Pasadena Christian School. Please forward this student's records and evaluations. This information is essential to our student support process. We thank you for your cooperation.

If you have any questions, please call Victoria Mele at (626) 791-1214, extension 277. Please forward the requested information to:

Emerging Needs Coordinator
Pasadena Christian School
1515 North Los Robles Avenue
Pasadena, CA 91104

**This authorization is in compliance with the terms of the Family Education Rights and Privacy Act and the code. Confidentiality of Medical Information Act of 1981, Section 56, et. seq., California Civil Code.*

Rev. 2/08