Galt Joint Union Elementary School District
1018 C Street, Suite 210, Galt, CA 95632
209-744 4521 / 209-745-5479 fax / www.galt.k12.ca.us

PINTERAGENCY AUTHORIZATION AND REQUEST FOR EXCHANGE OF INFORMATION

Student's Name ______________________________Birthdate: __________________

Address: ____

I hereby consent to the release and exchange of confidential information regarding the above student to and between the Galt Joint Union Elementary School District and any provider or agency with information relevant to this child's educational plan. I understand that the purpose of this release and exchange of information is to assist in developing the most appropriate educational setting for this child.
This authorization is in effect until ____________________ (date or event), when it expires.

The following types of information may be released:

- Diagnosis
- IEP/ITP/IWRP
- Aptitude Tests
- Psycho/Social Assessment
- All medical records from birth to present.
- 504 and IAP
- Psychological Tests
- Educational Records
- Other: ____

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_________________________________ _________________________________

Provider/Agency Ph. # Provider/Agency Ph. #

_________________________________ _________________________________

Address Fax # Address Fax #

_________________________________ _________________________________

City, State, ZIP City, State, ZIP

I understand that I may revoke this consent at any time. I understand that this information may accompany my child's confidential records upon transfer to another school district.

A COPY OR FAX OF THIS FORM IS AS VALID AS THE ORIGINAL.

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Signature of Parent/Legal Guardian/Authorized Representative Relationship to Student Date

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Printed Name