Travis Unified School District

CONFIDENTIAL

Bilateral Consent for Release of Information
School Year 2023-24

_____ _____

Client Name Date of Birth

I, _____ (parent/guardian), authorize the parties listed below to release to each other confidential information about my child named above including but not limited to history, functioning, symptoms, diagnosis, treatment, prognosis, etc., for the purpose of receiving appropriate mental health and/or support services at school. This information may also be shared with school staff as needed to identify, engage, and collaborate on additional supports or services your child might benefit from.

The parties are:

Name: Monica Padilla, MSW, PPSC **Title**: School Social Worker **School**: Travis Unified School District 2751 De Ronde Drive Fairfield, CA 94533 **Email:** mpadilla@travisusd.org **Phone**: 707-437-4604 ext. 9185 **Fax**: 707-448-4942 (Cambridge) 707-447-6055 (Foxboro)	**Name**: _____ **Title**: _____ **Agency**: _____ **Address:**_____ _____ **Email**: _____ **Phone**: _____ **Fax**: _____

I understand that this consent shall be valid for the entire duration of my child's services for the school year. I understand that I can revoke this release, in writing, at any time, except to the extent that it has already been acted upon.

_____ _____

Parent/Guardian Signature Date

Copy given to: ☐ Other Party ☐ Parent/Guardian ☐ Staff