PURPOSE: Signing this form will help connect your student to services they may be eligible for to support them as they move from the public school system to adulthood. If your consent is provided, the Office of Superintendent of Public Instruction (OSPI) will share information about your student to the state transition agencies named within this document to support transition and post-school services.

CONSENT TO SHARE CONTACT INFORMATION WITH STATE TRANSITION AGENCIES

Student name: _____ Date: _____

Student DOB: _____ School District: _____

Student information may include:

- Name
- Date of Birth
- Disability Category
- Grade
- Expected Graduation Date
- School District
- School
- ESD
- County

I understand that this information obtained will be treated in a confidential manner by the recipients under the provisions of the Family Education Rights and Privacy Act (FERPA). FERPA prohibits disclosure of personally identifiable information without consent except in limited circumstances. Please note that if the request is for health or medical information, the medical information received by the district is protected under FERPA privacy standards and not the Health Insurance Portability and Accountability Act (HIPAA).

This authorization is valid for up to five years, starting on: _____
Date

I hereby authorize the Office of Superintendent of Public Instruction to share my / my student's contact information with the Division of Social and Health Services, County agencies, and the Department of Services for the Blind and any other state agency working with individuals with intellectual and developmental disabilities.

_____ _____
Parent/guardian/adult student Signature *Date*