

Parent/Guardian Authorization for Release and Exchange of Information

PUPIL/PATIENT INFORMATION:

Date: _____

Name: _____
Last
First
M.

DOB: _____

I authorize the following individual(s) or organization(s) to release and exchange the above-named individual's medical/educational information as described below (check as needed):

- | | |
|---|--|
| <input type="checkbox"/> _____ School District
<input type="checkbox"/> CDE Diagnostic Center for Neurologically Handicapped Children
<input type="checkbox"/> California-Hawaii Elk's Major Project
<input type="checkbox"/> Central Valley Regional Center (CVRC)
<input type="checkbox"/> Community Regional Medical Center
<input type="checkbox"/> Department of Rehabilitation
<input type="checkbox"/> Exceptional Parents Unlimited (EPU)
<input type="checkbox"/> Fresno County Department of Social Services
<input type="checkbox"/> _____ Adult Day Program
<input type="checkbox"/> _____ | <input type="checkbox"/> Fresno County Economic Opportunities Commission-Head Start
<input type="checkbox"/> Fresno County Health Department/Human Services System (California Children's Services/MTU, Public Health Nursing, Children's Mental Health Services)
<input type="checkbox"/> Fresno County Office of Education
<input type="checkbox"/> Fresno County Probation Department
<input type="checkbox"/> United Cerebral Palsy
<input type="checkbox"/> Valley Children's Hospital _____ Dept
<input type="checkbox"/> _____ Hospital/Medical Center
<input type="checkbox"/> _____ Physician/Clinic/Other |
|---|--|

DESCRIPTION OF INFORMATION TO BE DISCLOSED AND EXCHANGED (CHECK AS NEEDED):

- | | | |
|---|--|--|
| <input type="checkbox"/> Immunization Record | <input type="checkbox"/> Operative Reports | <input type="checkbox"/> Ambulatory Clinic Summary |
| <input type="checkbox"/> Physician Orders | <input type="checkbox"/> Lab Results/X-ray Reports | <input type="checkbox"/> Appointment Dates/Times |
| <input type="checkbox"/> History and Physical | <input type="checkbox"/> Discharge Summary | <input type="checkbox"/> Mental Health Records |
| <input type="checkbox"/> Consultation Reports | <input type="checkbox"/> Educational Record | <input type="checkbox"/> Other: _____ |

I request that the information released and exchanged pursuant to this authorization be used for the following purposes only:

- | | |
|---|---|
| <input type="checkbox"/> Educational Assessment | <input type="checkbox"/> Health Care Planning |
| <input type="checkbox"/> Educational Planning | <input type="checkbox"/> Other: _____ |

To revoke any authorization granted herein, please send written notification to:
 (insert responsible educational agency's name & mailing address)

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PUPIL/PATIENT INFORMATION:

Date: _____

Name: _____
Last First M.

DOB: _____

DURATION:

This authorization shall become effective immediately and shall remain effective until _____ (date) of for one year from the date of signature if no date is entered.

REVOCAATION:

I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to the individual(s) and organization(s) identified in the box on Page 1 of this form. Written revocation will be effective upon receipt, but will not apply to information that has already been disclosed in response to this authorization.

REDISCLASURE:

I understand that protected health information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and it may no longer be protected by federal laws and regulations regarding the privacy of protected health information. I further understand the confidentiality of the information when released and exchanged to a public educational agency is protected as a student record under the Family Educational Rights and Privacy Act (FERPA).

HEALTH INFORMATION:

I understand that authorizing the disclosure of health information is voluntary. I can refuse to sign this authorization. I do not need to sign this form in order to assure medical treatment.

You may inspect or copy the information to be disclosed, as provided in CFR 164.524.

If a Personal Representative executes this form, that Representative warrants that he or she has authorization to sign this form on the basis of his or her legal relationship to the above referenced pupil. The Personal Representative executing this form warrants that his or her legal relationship to the above referenced pupil is: _____

Witness: _____

Parent/Guardian/Surrogate/Adult Student

Date

Print Name (Parent/Guardian/Surrogate/Adult Student)

A copy of this authorization is as valid as the original. I understand that I am entitled to receive a copy of this authorization.