TwinRivers UNIFIED SCHOOL DISTRICT

No Facsimiles Will Be Accepted for Release of Medical Information

SACRAMENTO COUNTY SPECIAL EDUCATION LOCAL PLAN AREA
AUTHORIZATION FOR USE AND/OR DISCLOSURE OF INFORMATION

_____ _____ _____
Name of student (list other names used) *Medical Record Number (if applicable)* *Date of Birth*

_____ _____ _____
Student Address *Phone* *Alt Phone*

I authorize the following individual or organization to disclose the above named individual's medical/educational information as described below:

Individual or Organization Disclosing Information:	**Individual or Organization Receiving Information:**
_____ *Disclosing party*	_____ *Receiving Party*
_____ *Address*	_____ *Address*
_____ *City, State, Zip Code*	_____ *City, State, Zip Code*
Telephone: _____ *FAX:* _____ Not valid for medical information	*Telephone:* _____ *FAX:* _____ Not valid for medical information

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

Revocation: I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to the releasing agency. Written revocation will be effective upon receipt, but will not apply to information that has already been released in response to this authorization.

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

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

Specify Record(s): Indicate type of information is to be disclosed:

☐ **Medical** ☐ **Medication** ☐ **Psychiatric** ☐ **Mental Health**

☐ **Drug/Alcohol** ☐ **STD/HIV Test Results** ☐ **Educational** ☐ **Other:** _____

Any and all information with regard to the above records may be released except as specifically provided here:

_____

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

☐ Educational Assessment ☐ Educational Planning ☐ Other: _____

A copy of this authorization is as valid as an original.
I understand that I have a right to receive a copy of this authorization for my records.

_____ _____ _____
Signature of Student or Student's Representative *Description of Relationship to Student* *Date*

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Rev 01/09