Parent/Guardian Authorization for Release and Exchange of Information

PUPIL/PATIENT INFORMATION: **Date**:_____

Name:_____ **DOB:** _____
Last First M.

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):

- ❒ _____School District
- ❒ CDE Diagnostic Center for Neurologically Handicapped Children
- ❒ California-Hawaii Elk's Major Project
- ❒ Central Valley Regional Center (CVRC)
- ❒ Community Regional Medical Center
- ❒ Department of Rehabilitation
- ❒ Exceptional Parents Unlimited (EPU)
- ❒ Fresno County Department of Social Services
- ❒ _____Adult Day Program
- ❒ Fresno County Economic Opportunities Commission-Head Start
- ❒ Fresno County Health Department/Human Services System (California Children's Services/MTU, Public Health Nursing, Children's Mental Health Services)
- ❒ Fresno County Superintendent of Schools
- ❒ Fresno County Probation Department
- ❒ United Cerebral Palsy
- ❒ _____ Hospital/Medical Center
- ❒ Valley Children's Healthcare _____ Dept(s)
- ❒ Physician/Clinic/Other: _____

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

- ☒ Immunization Record
- ☒ Physician Orders
- ☒ History and Physical
- ☒ Consultation Reports
- ☒ Operative Reports
- ☒ Lab Results/X-ray Reports
- ☒ Discharge Summary
- ☒ Educational Record
- ☒ Ambulatory Clinic Summary
- ☒ Appointment Dates/Times
- ☒ Mental Health Records
- ☒ Other: _____

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

- ❒ Educational Assessment
- ☒ Educational Planning
- ☒ Health Care Planning
- ☒ Other:_____

To revoke any authorization granted herein, please send written notification to:

Parent/Guardian Authorization for Release and Exchange of Information

PUPIL/PATIENT INFORMATION: **Date**:_____

Name:_____ **DOB**: _____
Last First M.

DURATION:
This authorization shall become effective immediately and shall remain effective 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 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.

REDISCLOSURE:
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.