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
- ☐ Central Valley Regional Center (CVRC)
- ☐ Clovis Community Hospital
- ☐ Community Regional Medical Center
- ☐ Department of Rehabilitation
- ☐ Exceptional Parents Unlimited (EPU)
- ☐ Diagnostic Center
- ☐ Fresno Community Hospital
- ☐ Fresno County Department of Social Services
- ☐ 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 Office of Education
- ☐ Fresno County Probation Department
- ☐ Kaiser Permanente Medical Center, Fresno
- ☐ Saint Agnes Medical Center
- ☐ Speech and Hearing
- ☐ UMC Children's Health Center
- ☐ University Medical Center (UMC)
- ☐ United Cerebral Palsy
- ☐ Valley Children's Hospital, Department of ____
- ☐ ____Physician/Clinic/Other
- ☐ ____Other/Miscellaneous

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

- ☐ Ambulatory Clinic Summary
- ☐ Appointment Dates/Times
- ☐ Audiological Test Results
- ☐ Consultation Reports
- ☐ Discharge Summary
- ☐ Educational Record
- ☐ Evaluation Reports
- ☐ History and Physical
- ☐ Immunization Record
- ☐ Lab Results/X-ray Reports
- ☐ Mental Health Records
- ☐ Operative Reports
- ☐ Physician Orders
- ☐ 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:
(insert responsible educational agency's name & mailing address)

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) of 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 45 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.