

GUSTINE UNIFIED SCHOOL DISTRICT  
Health Department's Phone Number: 209-600-2102

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Fax: 209-854-3784

**AUTHORIZATION AND REQUEST FOR RELEASE OF INFORMATION**

Student's Name: \_\_\_\_\_ Birth date: \_\_\_\_\_

I hereby authorize the release/exchange of health information pertinent to the pupil named above (Initial all that apply):

\_\_\_\_\_ **Medical** (including, but not limited to, diagnosis, treatment, and medication information).

\_\_\_\_\_ **Psychological** (Including, but not limited to, intellectual and psychological processing information)

\_\_\_\_\_ **Behavioral** (including, but not limited to, Behavioral Rating Scales, observations, and school disciplinary reports)

\_\_\_\_\_ **Neurological** (including, but not limited to, results of EEG, MRI, CAT, PET scans or assessments)

\_\_\_\_\_ **Educational** (including, but not limited to, academic achievement scores and pupil work)

\_\_\_\_\_ **Speech/language** (including, but not limited to, receptive, expressive, and language processing information)

\_\_\_\_\_ **Audiological** (Including, but not limited to, results of hearing tests and hearing aid information)

\_\_\_\_\_ **Other** (describe) \_\_\_\_\_

**Purpose for request of information** (Information may not be used for any other purpose or released to any other person(s) without written consent):

\_\_\_\_\_ To help determine eligibility for services

\_\_\_\_\_ To help develop an appropriate Individualized Education Program

\_\_\_\_\_ Other

(Describe): \_\_\_\_\_

**From:** (Name/Title Agency authorized to provide the information)

**To:** (authorized to receive and use information) Gustine Unified School District: GMS, GES, Romero, High School.

**Signature of Parent/Guardian:** \_\_\_\_\_ **Date:** \_\_\_\_\_

*"Note legal restrictions below.*

*With parent consent, copies of these records may be released to agencies serving the child. This authorization shall be valid for one year from the date of parent signature.*

*or until revoked in Writing by the parent or the Child once he/she turns eighteen years of age. I understand that I have the right to revoke this authorization at any time by notifying the school in Writing. I understand that the revocation is only effective after it is received and logged by the school. I understand that any use or disclosure made prior to the revocation under this authorization will not be affected by a revocation. A photocopy of this form shall be as valid as the original. I understand that I am entitled to receive a copy of this authorization. I understand that after this information is disclosed, federal law might not protect it and the recipient might disclose it.*

*I authorize the release of information specified above. I have been informed of and I understand my parental rights as detailed in the "Parent Rights and Procedural Safeguards for Special Education" information requested and received may be disclosed further by recipient with my written consent and may not be protected by federal privacy rules, I warrant that I have authority to sign this form on the basis of Civil Code section 56.10.*

*\* Enrollment or eligibility will not be conditioned on receipt of the authorization.*