

Parent/Guardian Authorization for Release of Information

Pupil: _____
Last, First, Initial

Date: ____/____/____

Please send the requested information to:

Attn: _____, Title _____

Phone: _____, Fax: _____

I authorize the following individual or organization to disclose the above named individual's medical/educational information as described below and this information is to be released from: (check as needed)

- | | |
|--|--|
| <input type="checkbox"/> _____ School District | <input type="checkbox"/> Valley Oak Hospital |
| <input type="checkbox"/> California Children's Services (CCS) | <input type="checkbox"/> Shriner's Hospital |
| <input type="checkbox"/> CCS Medical Therapy Unit | <input type="checkbox"/> Oakland Children's Hospital |
| <input type="checkbox"/> Valley Mtn. Regional Center/Regional Center | <input type="checkbox"/> Fresno Diagnostic Clinic |
| <input type="checkbox"/> Stanislaus County Health Services Agency | <input type="checkbox"/> University Medical Center |
| <input type="checkbox"/> Stanislaus County Office of Education | <input type="checkbox"/> Lucille Packard Children's Hospital |
| <input type="checkbox"/> Golden Valley Health Centers | <input type="checkbox"/> Gould Medical Group |
| <input type="checkbox"/> Doctor's Medical Center | <input type="checkbox"/> Kaiser Permanente Medical Group |
| <input type="checkbox"/> Emanuel Hospital | <input type="checkbox"/> Infant Referral Program/Early Start |
| <input type="checkbox"/> Memorial Hospital | <input type="checkbox"/> Children's Hospital - Central CA |
| <input type="checkbox"/> DMC Foundation | |
| <input type="checkbox"/> Physical / Clinic / Other _____ | |
| <input type="checkbox"/> Physical / Clinic / Other _____ | |
| <input type="checkbox"/> Physical/ Clinic / Other _____ | |

Description of information to be disclosed (check as needed):

- | | | |
|---|--|--|
| <input type="checkbox"/> Medical Records | <input type="checkbox"/> Educational Records | <input type="checkbox"/> Lab Results/X-Ray Reports |
| <input type="checkbox"/> Medication Information | <input type="checkbox"/> Mental Health Information | <input type="checkbox"/> STD/HIV Test Results |
| <input type="checkbox"/> Physician Orders | <input type="checkbox"/> Psychiatric Information | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Immunization Records | <input type="checkbox"/> Drug/Alcohol Information | <input type="checkbox"/> Other: _____ |

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Pupil: _____ Date: _____
Last, First, Initial

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

- | | |
|------------------------------|--------------------|
| _____ Educational Assessment | _____ Other: _____ |
| _____ Educational Planning | _____ Other: _____ |
| _____ Health Care Planning | _____ Other: _____ |

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 entity and individual identified in the box at the bottom 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.

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.

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 this his or her legal relationship to the above referenced pupil is: _____

Witness: _____

Parent/Guardian/Surrogate

Date

Print Name (Parent/Guardian/Surrogate)

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