EL DORADO UNION HIGH SCHOOL DISTRICT

AUTHORIZATION FOR USE AND/OR DISCLOSURE OF INFORMATION

Completion of this document authorizes the disclosure/release and/or use of individually identifiable health information, as set forth below, consistent with federal and State Laws concerning the privacy of such information. Failure to provide all information requested may invalidate this authorization.

NAME OF STUDENT (LIST OTHER NAMES USED)	MEDICAL RECORD NUMBER (IF APPLICABLE)	DATE OF BIRTH
ADDRESS OF STUDENT	PHONE NO.	OTHER PHONE NO.

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:

Disclosing party

Address

City, State, Zip Code

Telephone *Fax*

Individual or Organization Receiving Information:

Receiving Party

Address

City, State, Zip Code

Telephone *Fax*

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 release 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 the Requestor (School District) will protect this information as prescribed by the Family Equal Rights Protection (FERPA) and that the information becomes part of the student's educational record. The information will be shared with individuals working at or with the School District for the purpose of providing safe, appropriate, and least restrictive educational settings and school health services and programs.

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 Representatives *Relationship to Student* *Date*