fresno county
office of education

Larry L. Powell
Superintendent

Authorization to Release Information

A. ***STUDENT/PATIENT INFORMATION***:
Name:____ **DOB**:__________
Last First M.

B. ***PARENT/LEGAL GUARDIAN NAME***: _____________________________________

C. ***INFORMATION TO BE RELEASED FROM***:

- ☐ _______________School District
- ☐ Association for Retarded Citizens
- ☐ CDE Diagnostic Center for Neurologically Handicapped Children
- ☐ California-Hawaii Elk's Major Project
- ☐ Central Valley Regional Center (CVRC)
- ☐ Children's Hospital Central California
  _________________ Department
- ☐ Department of Rehabilitation
- ☐ Exceptional Parents Unlimited (EPU)
- ☐ 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
- ☐ _________________Hospital/Medical Center
- ☐ United Cerebral Palsy
- ☐ UMC Children's Health Center
- ☐ United Cerebral Palsy
- ☐ Adult Day Program: ____
- ☐ Physician/Clinic/Other: ____

D. ***INFORMATION TO BE RELEASED TO AND USED BY:***________________________

_________________ _________________ _____________ _____________
School/Department Contact Person Phone FAX

____
Address City State Zip

E. ***PURPOSE OF REQUESTED INFORMATION***:

- ☐ Authorization forwarded at the request of the Parent/Legal Guardian
- ☐ Assistance in determining most appropriate school education program/learning accommodations
- ☐ Other:____

F. ***TYPE/DESCRIPTION OF INFORMATION REQUESTED***:

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

G. ***DATE(S) OF SERVICE***: From ________________ To ______________________

H. ***PERSON AUTHORIZING RELEASE OF INFORMATION***:
I understand that the information released may include information regarding: treatment, hospitalization, or outpatient care, including psychological/psychiatric impairment, drug abuse, alcoholism, AIDS, or HIV tests, and confidential records maintained for educational use, unless otherwise excluded below: ______________________________

I understand that the school district is responsible for maintaining confidential files for access and review by involved educational staff only. Academic, psychological and health records are exchanged among California Public Schools.

I have read and understand the "Authorization Restrictions and Rights" on the back of this form which includes my right to refuse to sign this authorization, revoke this authorization, and receive a copy of this authorization.

Unless revoked, this authorization will expire in 1 year. Specify if less than 1 year: ____

I. ***REDISCLOSURE (HIPAA)***:
I understand that health information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and it is no longer protected by federal laws and regulations regarding the privacy of protected health information. I further understand the confidentiality of the information when released to a public educational agency is protected as a student record under the Family Educational Rights and Privacy Act (FERPA).

______________________________	______________________
Signature of Parent/Legal Guardian	**Date**
______________________________	______________________
Signature of Student (Adult)	**Date**
______________________________	______________________
Signature of Witness	**Date**

Authorization to Release Information

- Signing this authorization is voluntary. You can refuse to sign this authorization. Refusing to sign this authorization will not affect the Requesting Educational Entity's commitment to providing a quality education for your child; however, refusing to sign may inhibit the school's ability to implement an optimal plan of education, learning accommodations and/or health care plan for your child.

- This authorization may be revoked at any time. To revoke this authorization, you must provide the organization or individual listed in Section B of this form, with a written request to revoke the authorization. Any information disclosed before your written revocation is received may be used as previously permitted.

- You have the right to receive a copy of your "*Authorization for Release of Information*". If you request it, you will receive a copy of this authorization after you sign it.

- The Requesting Educational Entity is responsible for maintaining confidential files for access and review by involved educational staff only. Academic, psychological and health records are exchanged among California Public Schools. No further disclosure of this information by the Requesting Educational Entity should be done without specific, written and informed release of parent/legal guardian.

- If you authorize disclosure of information to a person or entity that is not legally required to keep it confidential, the information may be re-disclosed and may no longer be protected by state or federal law.

- You may inspect or copy the information to be disclosed, as provided in CFR 164.524.