Azusa Unified School District

546 South Citrus Avenue . P.O. Box 500 . Azusa, CA 91702-0500

AUTHORIZATION FOR USE OR DISCLOSURE OF INFORMATION

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

PATIENT/STUDENT NAME _____ _____

Last First Middle Date of Birth

I, the undersigned, authorize the ☐ **Release** ☐ **Exchange** ☐ **Request**

RECORDS/INFORMATION FROM:

Person/Agency: _____

Address: _____

City/State/Zip: _____

Telephone #: _____

FAX#: _____

SEND RECORDS/INFORMATION TO:

Person/Agency: _____

Address: _____

City/State/Zip: _____

Telephone #: _____

FAX#: _____

- ☐ Psychiatric/Mental Health Records/ Information (CA W & I Code Section 5328)
- ☐ Diagnosis
- ☐ Medication Records
- ☐ Discharge Summary
- ☐ Medical Records (Civil Code 56.10, Title 17)
- ☐ Lab Results Specify: _____
- ☐ Alcohol/Substance Abuse Treatment Records/Information (Section 42, CFR, Part 2) - Cannot be combined w/ any other categories
- ☐ DCFS Records (please specify): _____
- ☐ School Records (i. e., academics, attendance, immunizations. IEP, 504, etc.)
- ☐ Psychological/DIS Test Results

Duration:

This authorization shall become effective immediately and shall remain in effect until _____ 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 releasing agency. Written revocation will be effective upon receipt but will not apply to information that has already been released in response to this authorization.

Re-disclosure:

I understand that the requestor (School District) will protect this information as prescribed by the Family Equal Rights Protection Act (FERPA) and that the information becomes part of the student's permanent educational record. The information will be shared with individuals working at or with the School District for the purpose of providing a safe, appropriate, and least restrictive educational setting and school health services program.

Health Information:

I understand that authorizing the disclosure of health information is voluntary and I have the right to receive a copy of the authorization. Signing this authorization may be required in order for this student to obtain appropriate services in the educational setting.

A copy of this authorization is as valid as an original.

Approval:

_____ _____ _____ _____

Printed Name Signature Relationship to Patient/Student Date

_____ ( ) _____ _____

Address City Zip Code Phone Number Copy Received (Initials)

Education - the Torch that Lights the Path of Knowledge