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| **DESERT/MOUNTAIN SPECIAL EDUCATION LOCAL PLAN AREA****DESERT/MOUNTAIN CHARTER SPECIAL EDUCATION LOCAL PLAN AREA**17800 HIGHWAY 18 • APPLE VALLEY, CA 92307(760) 552-6700 • (760) 242-5363 FAX**Authorization for Use and/or Disclosure of Information** |
| **STUDENT INFORMATION** |
| Student Name: |       | Date of Birth: |       | Medical Record No: |       |
| School Site: |       | District of Attendance: |       |
| Street Address: |       | City: |       | State: |       | Zip Code: |       |
| Home Phone: |       | Cell Phone: |       | Other Phone: |       |
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| **AUTHORIZATION** |
| **I authorize the following individuals to disclose the above-named individual’s medical and/or educational information:** |
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| **RECEIVINING****AGENCY** | Individual/Agency **Receiving** Information: |       |
|  |  |  |  |  |  |  |
| Street Address: |       | City: |       | State: |       | Zip Code: |       |
|  |  |  |  |  |  |
| Contact Phone: |       | Fax: |       |
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| **DISCLOSING****AGENCY** | Individual/Agency **Disclosing** Information: |       |
|  |  |
| Street Address: |       | City: |       | State: |       | Zip Code: |       |
|  |  |  |  |  |  |  |  |
| Contact Phone: |       | Fax: |       |
|  |  |  |  |
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| **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. | **(Date)** |  |
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| **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. |
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| **REDISCLOSURE:** I, |  | understand that educational and health information used or |
| disclosed pursuant to this authorization may be subject to redisclosure by the receipient 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). |
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| **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. |
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| **SPECIFY RECORD(S):** | Indicate type of information to be disclosed: |
|  | [ ]  | Medical/Medication | [ ]  | Drug/Alcohol |
|  | [ ]  | Mental Health/Psychiatric | [ ]  | STD/HIV Test Results |
|  | [ ]  | Educational Records | [ ]  | Other: |       |
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| I request that the information released pursuant to this Authorization be used for the following purposes: |
|  | [ ]  | 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.** |
|  |  |  |  |  |  |
| Date: |       | Student/Representative Signature: |  | Relationship to Student: |       |
| Date: |       | Parent/Guardian Signature: |  |