



AUTHORIZATION FOR EXCHANGE, DISCLOSURE AND USE OF HEALTH INFORMATION TO SCHOOL DISTRICTS

Completion of this document allows the physician or other health care provider to exchange information with the Cajon Valley Union School District about your child’s health and medical history, as set forth below, consistent with California and Federal laws (e.g., HIPAA) concerning the privacy of such information. Failure to provide all information requested may invalidate this authorization.

USE AND DISCLOSURE INFORMATION:

Student/Patient Name: _____ DOB: _____

I, the undersigned, do hereby authorize (name of agency and/or health care providers):

(1) _____ (2) _____

to provide health information from the above-named child’s medical record to and from:

_____	_____	_____
School District to Which Disclosure is Made	Address / City and State / Zip Code	
_____	_____	_____
Contact Person at School District	Telephone Number	Fax Number

The disclosure of health information is required for the following purpose:

Requested information shall be limited to the following: All health information **or** Disease-specific information as described:

DURATION:

This authorization shall become effective immediately and shall remain in effect until _____ (enter date) or for one year from the date of signature, if no date entered.

RESTRICTIONS:

California law prohibit the Requestor from making further disclosure of my child’s health information unless the Requestor obtains an authorization form from me for such additional disclosure, or if such additional disclosure is specifically required or permitted by law.

YOUR RIGHTS:

I understand that I have the following rights with respect to this Authorization: I may revoke this Authorization at any time. My revocation must be in writing, signed by me or on my behalf, and delivered to the health care agencies/persons listed above. My revocation will be effective upon receipt, but will not be effective to the extent that the Requestor or others have acted in reliance to this Authorization. I have a right to receive a copy of this Authorization. Signing this Authorization may be required in order for this student to obtain appropriate services in the educational setting.

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 educational record. The information will be shared with individuals working at or with the School District for purposes of providing safe, appropriate, and least restrictive educational settings, programs and services.

APPROVAL:

_____	_____	_____
Printed Name	Signature	Date
_____	_____	
Relationship to Patient/Student	Area Code and Telephone Number	



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Page 2 is Optional

Student/Patient Name: _____ DOB: _____

<p>Significant Data/ Information Requested</p>	
<p>Findings/ Recommendations</p>	