

Santa Monica-Malibu Unified School District
AUTHORIZATION FOR DISCLOSURE OF MEDICAL AND/OR EDUCATIONAL INFORMATION

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 _____ to:
[name of Student/Student's Rep] [Name of Educational Agency]

Release the above-named individual's medical and educational information as identified below **to:**

Obtain the above-named individual's medical and educational information as identified below **from:**

Individual or Organization Receiving Information

Individual or Organization Disclosing Information

SMMUSD Health Services, Attn: School Nurse <i>Receiving Party</i>
_____ <i>Address</i>
Santa Monica, CA 90401
_____ <i>City, State, Zip Code</i>
310-450-8338/310-450-9862
_____ <i>Telephone/Fax</i>

_____ <i>Disclosing Party</i>
_____ <i>Address</i>
_____ <i>City, State, Zip Code</i>
_____ <i>Telephone/Fax</i>

Duration: This authorization shall become effective immediately and shall remain in effect for one year from the date of signature.

Revocation: I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to the **disclosing** 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 medical/educational information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and it **may** no longer be 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).

Health Info: 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.

Specify Record(s): Indicate type of information that is to be disclosed.

- | | | | |
|---|---|--|--|
| <input type="checkbox"/> Medical Information | <input type="checkbox"/> Medication Information | <input type="checkbox"/> Psychological/Psychiatric Information | <input type="checkbox"/> Mental Health |
| <input type="checkbox"/> Drug/Alcohol Information | <input type="checkbox"/> Educational Records | <input type="checkbox"/> Other: _____ | |

Qualification for consideration of education services is dependent upon a qualifying diagnosis by the disclosing party.

I request that the information released pursuant to this authorization be used for the following purposes only:

- | | | |
|---|---|---------------------------------------|
| <input type="checkbox"/> Educational Assessment | <input type="checkbox"/> Educational Planning/IEP development | <input type="checkbox"/> Other: _____ |
|---|---|---------------------------------------|

A copy **or facsimile** 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 **or my child/ward's** records.
I understand that I may request to inspect or obtain a copy of the information to be used or disclosed.

Signature of Student or Student's Representative

Description of Relationship to Student

Date

NOTE: Original signature is required for release of medical information. No facsimile of this form will be accepted when requesting the disclosure of medical information.