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	*Home Telephone Number*	*Other Telephone Number*

I, _____, authorize SMMUSD to:
[Name of Student/Student's Representative] [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* *Receiving Party* 1717 Fourth Street *School Nurse E-mail:* *Address* Santa Monica, CA 90401 *City, State, Zip Code* 310-450-8338/310-450-9862 *Telephone/Fax*	_____ *Disclosing Party* _____ *Address* _____ *City, State, Zip Code* _____ *Telephone/Fax*

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 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.

☑ Medical Information ☐ Medication Information ☐ Psychological/Psychiatric Information ☐ Mental Health

☐ Drug/Alcohol Information ☐ Educational Records ☐ 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:

☐ Educational Assessment ☐ Educational Planning/IEP development ☑ Other: Health Care while at school

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.