Madera-Mariposa SELPA

Authorization for Release/Exchange of Protected Health and Educational Information

A. STUDENT/PATIENT INFORMATION

Name: _____
LAST FIRST MI

Date of Birth: _____ Sex: ____ M ____ F Student ID#: _____

B. TYPE/DESCRIPTION OF INFORMATION REQUESTED

___ Educational/Special Education Records
___ Immunization Record
___ History and Physical
___ Physician Orders
___ Ambulatory Clinic Summary
___ Operative Reports
___ Appointment Dates/Times
___ Lab/X-ray Reports
___ Discharge Summary
___ Consultation Reports
___ Mental Health Records
___ Other: _____

C. INFORMATION TO BE RELEASED FROM (✕ as needed):

___ _____ School District
___ California Children's Services (CCS)
___ Camarena Health Centers
___ Central Valley Regional Center (CVRC)
___ Clovis Community Medical Center
___ Community Action Partnership of Madera County
___ Community Regional Medical Center (CRMC)
___ Exceptional Parents Unlimited (EPU)
___ Fremont Hospital
___ Fresno County Office of Education
___ Kaiser Permanente MC, Fresno
___ Madera Community Hospital
___ Madera Co. Behavioral Health Services (will require additional forms)
___ Madera Co. Dept. of Social Services (will require additional forms)
___ Madera Co. Probation Department
___ Madera Co. Public Health
___ Mariposa Counseling Center
___ Saint Agnes Medical Center
___ UMC Children's Health Center

___ **Valley Children's Healthcare**
___ Charlie Mitchell Clinic
___ Genetics
___ PT/OT
___ Rehabilitation
___ Special Clinics
___ Speech and Hearing
___ Other: _____

___ Educational Agency: _____
Physician: _____
Clinic: _____
Other: _____

___ Educational Agency: _____
Physician: _____
Clinic: _____
Other: _____

D. INFORMATION TO BE RELEASED TO AND USED BY:

_____

School/Department: _____ Contact Person: _____

Address _____ City _____ State _____ Zip _____

Phone: _____ Fax: _____

E. PURPOSE OF THE REQUESTED INFORMATION

___ Authorization forwarded at the request of Parent/Legal Guardian/Surrogate

___ Assist in determining most appropriate school education program/learning accommodations/educational assessment

___ Other: _____

F. SIGNATURE AUTHORIZING RELEASE OF INFORMATION

By signing below, I understand that the information released may include information regarding treatment, hospitalization, or outpatient care, including psychological/ psychiatric impairment, drug abuse, alcoholism, AIDS, or HIV tests, unless otherwise excluded here:

_____

_____

I also understand that the school district is responsible for maintaining confidential files for access and review by involved educational staff only. Academic, psychological and health records are exchanged among California public schools.

I have read and understand the "Authorization Restrictions and Rights" on the backside of this form which includes my right to refuse to sign this authorization, to revoke this authorization, to receive a copy of this authorization and that a copy of this authorization is as valid as an original.

Unless revoked, this authorization will expire in 1 year, unless otherwise specified here:

_____

_____ _____

Signature of Parent/Legal Guardian/Surrogate Date

_____ _____

Signature of Witness Date

Authorization Restrictions and Rights

Duration: This authorization shall become effective immediately and shall remain in effect, unless revoked, 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 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.

Redisclosure: I understand that health information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient 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).

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.