BONITA UNIFIED SCHOOL DISTRICT AUTHORIZATION FOR DISCLOSURE OF MEDICAL AND/OR EDUCATIONAL INFORMATION

Name of student (list other names used)		Medica	Medical Record Number (if applicable)		Date of Birth
Address of student			Phone No.		Other Phone No.
I,, authorize the B			Bonita Unified School District [Name of Educational Agency]		to:
X Release the above-named individual's <i>medical</i> /education Information as identified below <u>to:</u>			X Obtain the above-named individual's <i>medical</i> /educational information as identified below <u>from:</u>		
Individual or Organization Receiving Information			Individual or Organization Receiving Information		
Receiving Party			Recei	ving Party	
Address			Address		
City, State, Zip Code			City, State, Zip Code		
Telephone/Fax			Telephone/Fax		
Duration: Revocation:	This authorization shall become effective immediately and shall remain in effect until (date) or for one year from the date of signature if no date is entered. I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to the <i>disclosing</i> 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 redisclosure by the recipient and it <i>may</i> 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 Drug/Alcohol Information		Medication Information Educational Records		Psychiatric Information Other:	Mental Health
Oualification	for consideration of educa	ation services is der	oendent up	on a qualifying diagnosis by t	the disclosing party.
-		-	-	on be used for the following p	
Educational Assessment		Educational Plan	ning	Other:	
	I understand that I have a r	• •	his authorizati	valid as an original. ion for my or my child/ward's records e information to be used or disclosed.	
Signature of Student	t or Student's Representati	ve Descrip	otion of Rel	ationship to Student	Date