BONITA 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 Bonita Unified School District_____ to:
[name of Student/Student's Rep] [Name of Educational Agency]

X Release the above-named individual's ***medical***/educational Information as identified below **to:**

Individual or Organization Receiving Information

_____
Receiving Party
_____
Address
_____
City, State, Zip Code
_____
Telephone/Fax

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

Individual or Organization Receiving Information

_____
Receiving Party
_____
Address
_____
City, State, Zip Code
_____
Telephone/Fax

Duration: 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.

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 ☐ 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 ☐ 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*

Rev 08/16