**HAYWARD UNIFIED SCHOOL DISTRICT**

**STUDENT AUTHORIZATION FOR RELEASE OF INFORMATION**

Student Information\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Information to be Released From:

Agency/Person: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Fax: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Information to be Released to and Used By:

Agency: Hayward Unified School District (“HUB”) Attention:

Address: 24823 Soto Rd. Hayward, CA 94544 School Nurse

Phone: **Offic**e: , ext. **Cell**: **Fax**: 510-582-8805

Purpose of Requested Information

Release of health info at the request of student’s parent, guardian or legal representative

Provide and plan educational services for student

Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Records: Check the box, initial and/or sign to specify which type of information is to be disclosed.

**MEDICAL SUMMARIES \_\_\_\_\_\_\_\_\_\_** (initial)

**PHYSICAL EXAM \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_**

**Signature Date**

**PSYCHIATRIC RECORDS \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_**

**Signature Date**

**IMMUNIZATION RECORDS \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_**

**Signature Date**

**LAB/X-RAY/TEST RESULTS \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_**

**Signature Date**

**VERBAL EXCHANGE \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_**

**Signature Date**

**OTHER HEALTH INFORMATION \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_**

**Signature Date**

Specify the records to be disclosed: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**DURATION:** This authorization shall become effective immediately and shall remain in effect for one year from the date of signature unless a different date is specified here \_\_\_\_\_\_\_\_ (Date)

**REVOCATION:** This authorization is also subject to written revocation by the patient/guardian at any time. The written revocation will be effective upon receipt, except to the extent that the disclosing party or others have acted in reliance upon this authorization.

**REDISCLOSURE:** I understand that the recipient may not lawfully further use or disclose the health information unless another authorization is obtained from me or unless such use or disclosure is specifically required or permitted by law.

A copy of this authorization is as valid as the original. Parent/Guardian has a right to a copy of this authorization.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Signature Date**