

Please complete and return to the Health Clerk at school site

SANTA CLARA COUNTY
Fremont Union High School District
HIPPA PRIVACY AUTHORIZATION FOR
RELEASE OF MEDICAL/EDUCATIONAL INFORMATION FOR STUDENTS

Student Name: \_\_\_\_\_ Medical Record Number/ID Number \_\_\_\_\_ DOB \_\_\_\_\_

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

Table with 2 columns: PERSON/ORGANIZATION INFORMATION WILL BE REQUESTED FROM: and DISTRICT AUTHORIZED PERSON INFORMATION WILL BE SENT AND/OR DISCLOSED TO:.

Check box to specify information requested and to be released: (Parent/Guardian to initial)

- Checkboxes for: Psycho-educational evaluations/records, Speech & Language records, Mental health records, Individualized Education Programs (IEPs), Educational, Exchange of written or verbal information between the agencies listed above, Vision evaluations, Hearing/Audiological evaluation, Medical records pertaining to, Birth records.

DESCRIPTION OF EACH PURPOSE FOR THE USE OF RELEASE OF THE INFORMATION
(Provide detailed description of the activity for which the information will be used)

Phone call and possible letter regarding school needs as needed

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)

I understand that the District Authorized Representative shall have full authority to request and receive information in regards to my child as stated above and within the effective timeline. I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to the school district representative requesting the information. Written revocation will be effective upon receipt, but will not apply to information that has already been released in response to this authorization.

I understand that health information used or disclosed pertaining to this authorization may be subject to re-disclosure by the receiving agency and that the information requested may no longer be 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).

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, except under specific circumstance in the case of the request for physician orders, in accordance with Education Code Section 49423.5 to provide specialized physical health care services and/or care to students with health conditions (for example: asthma, diabetes, epi-pen, gastrostomy feeding, medications, etc.) during school hours.

I consent to the release of the information indicated above and acknowledge that I have received a copy of this release; A copy of this authorization is considered valid.

Parent\* Signature Date

\* "Parent" may refer to any person having legal custody of the child (eg.: biological, adoptive, or foster parents); any adult student without a guardian or conservator; a person acting as the child's parent if neither the parent nor guardian can be notified of the educational actions under consideration; or an appointed surrogate parent. "Parent" does not include a nonpublic, nonsectarian school or agency under contract with LEA. [EdCode 56028]

ACKNOWLEDGEMENT

I, Jung Yeun Hong RN, MSN FUHSD School Nurse Specialist, have read the above as related to designation of District Authorized Representative and I hereby

accept this designation as District Authorized Representative for the following student \_\_\_\_\_

Signature of District Authorized Representative Date