SANTA CLARA COUNTY

SPECIAL EDUCATION LOCAL PLAN AREA

HIPPA PRIVACY AUTHORIZATION FOR RELEASE OF MEDICAL/EDUCATIONAL INFORMATION FOR STUDENTS

Student Name _____

Medical Record Number/ID Number _____ DOB _____/_____/_____

Address _____ City _____

State _____ Zip _____ Telephone _____

PERSON/ORGANIZATION INFORMATION WILL BE REQUESTED FROM:	DISTRICT AUTHORIZED PERSON INFORMATION WILL BE SENT AND/OR DISCLOSED TO:
Name:	Name:
Address:	Address:
City/State/Zip	City/State/Zip:
Telephone: Fax:	Telephone: Fax:

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

_____ ☐ Psycho-educational evaluations/records

_____ ☐ Speech & Language records

_____ ☐ Mental health records

_____ ☐ Individualized Education Programs (IEPs)

_____ ☐ Medical records pertaining to _____

_____ ☐ Other records (Specify) _____

_____ ☐ Exchange of written or verbal information between the agencies listed above

_____ ☐ Vision evaluations

_____ ☐ Hearing/Audiological evaluation

_____ ☐ Birth records

_____ ☐ Cumulative File

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)

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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, _____, have read the above as related to

Name of District Authorized Representative

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*