Buena Park School District
NOC SELPA

Name of Student	Medical Number (If Applicable)	Date of Birth
Address of Student	Phone Number	Other Phone Number

I authorize the following individual or organization to disclose the above named individual's medical/educational information as described below:

Individual or Organization Receiving Information	**Individual or Organization Disclosing Information**
Buena Park School District Receiving Party	Releasing Party
6885 Orangethorpe Ave. Address	Address
Buena Park, CA 90620 City, State, Zip	City, State, Zip
714-736-4257 Telephone	Telephone
714-670-7188 Fax	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 ☐ Educational Records ☐ Drug/Alcohol Information

☐ Post-secondary ☐ Other :_____

I understand and authorize for the above mentioned parties to disclose information as specified and that I have a right to receive a copy of this authorization for my records.

Signature of Parent/Guardian/Adult Student	*Relationship to Student*	*Date*

A copy of this authorization is as valid as the original document