FREMONT UNION HIGH SCHOOL DISTRICT

Cupertino High School | Fremont High School | Homestead High School | Lynbrook High School | Monta Vista High School | Adult School

HIPAA PRIVACY AUTHORIZATION FOR RELEASE OF STUDENT MEDICAL/EDUCATIONAL INFORMATION

Student Name: _____ DOB: ___/___/___

Medical Record Number/ID Number: _____

Address: _____ City: _____

State: _____ Zip: _____ Telephone: _____

PERSON/ORGANIZATION INFORMATION WILL BE REQUESTED FROM:	PERSON/ORGANIZATION INFORMATION WILL BE SENT AND/OR DISCLOSED TO:
Clinic/Medical Center(s):	**District** Fremont Union High School District
Healthcare Provider Name:	**School:**
Address:	**Requesting Personnel:**
City/State/Zip:	**Telephone:**
Telephone: **Fax:**	**Fax:**

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

_____ ❑ Psycho-educational evaluation/records

_____ ❑ Health and Developmental

_____ ❑ Speech & Language records

_____ ❑ Hearing/Audiological Evaluation

_____ ❑ Medical records pertaining to: _____

_____ ❑ FUHSD Home Teaching Program

_____ ❑ Vision Evaluation

_____ ❑ Educational

_____ ❑ Mental Health records

_____ ❑ Birth records

_____ ❑ Other records (specify):

_____

DESCRIPTION OF EACH PURPOSE FOR THE USE OF RELEASE OF THE INFORMATION (Provide detailed description of the activity of which the information will be used)
• Exchange of written or verbal information between the agencies listed above • Phone call and possible letter regarding school needs, as needed. • Clarification of medical information. • Verification of medical conditions. • School accommodations.

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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) or medical provider has changed.

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]