MT. DIABLO UNIFIED SCHOOL DISTRICT

1936 Carlotta Drive, Concord, CA 94519
Phone (925) 682-8000 or TDD 685-2962

RELEASE OF STUDENT INFORMATION AUTHORIZATION TO OR FROM MT. DIABLO UNIFIED SCHOOL DISTRICT

FAX (925)687-3139
Community Advisory Committee (CAC)
Parent Resource Network (925)687-2129

THIS FORM MUST BE COMPLETELY FILLED OUT BEFORE REQUESTING PARENT SIGNATURE

Do not leave areas blank. Mark n/a where appropriate.

Name of Student (list other names used) _____ School of Attendance _____ Date of Birth _____

Address of Student _____ Phone No. _____ Other Phone No. _____

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

Individual or Organization Disclosing Information:	**Individual or Organization Receiving Information:**
Disclosing Party	Receiving Party
Address	Address
City State Zip Code	City State Zip Code
Telephone FAX	Telephone 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 releasing 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 health information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and it is 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 is to be disclosed:

- ❑ Educational Records
- ❑ Special Education Records/Assessments
- ❑ Medical/Medication Information: Medical Record # _____
- ❑ Mental Health
- ❑ Other: specify _____

I request that the information released pursuant to this authorization be used for the following purposes only:

❑ Educational Assessment ❑ Educational Planning ❑ Other: _____

A copy of this authorization is as valid as an original. I understand that I have a right to receive a copy of this authorization for my records.

Date _____ Signature of Parent or Legal Guardian _____ Relationship to Student _____

Transmission of this information to individuals or agencies not listed is prohibited without written consent. (E.C. 49075)
Note: This authorization is to be made a permanent part of the student's record in accordance with State and Federal regulations.