Turlock Unified School District

P.O. Box 819013 · Turlock, CA 95381-9013 · Ph. (209) 667-0887 · Fax (209) 667-6441

Parent/Guardian Authorization for Release of Information

Pupil Name: _____ Date of Birth: _____
Last First Initial

I authorize the following individual or organization to disclose the above named individual's medical/educational information as described below and this information is to be released from (check as needed):

___ _____School District
___ California Children's Services (CCS)
___ CCS Medical Therapy Unit
___ Valley Mtn. Regional Center/Regional Center
___ Stanislaus County Health Services Agency
___ Stanislaus County Office of Education
___ Golden Valley Health Centers
___ Doctor's Medical Center
___ Emanuel Hospital
___ Memorial Hospital
___ Physician/Clinic/Other_____
___ Physician/Clinic/Other_____
___ Physician/Clinic/Other_____
___ Valley Oak Hospital
___ Shriner's Hospital
___ Oakland Children's Hospital
___ Fresno Diagnostic Clinic
___ University Medical Center
___ Lucille Packard Children's Hospital
___ Gould Medical Group
___ Kaiser Permanente Medical Group
___ Infant Referral Program/Early Start
___ Children's Hospital – Central CA

Description of information to be disclosed (check as needed):

___ Medical Records
___ Medication Information
___ Physician Orders
___ Immunization Records
___ Educational Records
___ Mental Health Information
___ Psychiatric Information
___ Drug/Alcohol Information
___ Lab Results/X-Ray Reports
___ STD/HIV Test Results
___ Other _____
___ Other _____

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

___ Educational Assessment
___ Educational Planning
___ Health Care Planning
___ Other _____
___ Other _____
___ Other _____

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.

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Revocation: I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to the entity and individual identified in the box at the bottom of this form. Written revocation will be effective upon receipt, but will not apply to information that has already been disclosed in response to this authorization.

Redisclosure: I understand that protected health information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and it may no longer be protected by federal laws and regulations regarding the privacy of protected health information.

Health Information: 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 for in order to assure medical treatment.

If a Personal Representative executes this form, that Representative warrants that he or she has authorization to sign this form on the basis of his or her legal relationship to the above referenced pupil. The Personal Representative executing this form warrants that his or her legal relationship to the above referenced pupil is _____.

_____ _____
Parent/Guardian/Surrogate Signature Date

_____
Print Parent/Guardian/surrogate Name

Please send the requested information to:

Attn: _____ Title: _____

_____

_____

_____

Phone: _____ FAX: _____

A copy of this authorization is as valid as the original. I understand that I am entitled to receive a copy of this authorization.