

# BRADFORD ELEMENTARY SCHOOL

Part of the Oxbow Unified Union School District | A Community of Learners Empowered Through Experience

## REQUEST FOR AND AUTHORIZATION TO RELEASE INFORMATION

I hereby authorize:

- My child's health care provider: (Name) \_\_\_\_\_ (Phone) \_\_\_\_\_  
(Address) \_\_\_\_\_
- My child's mental health provider: (Name) \_\_\_\_\_ (Phone) \_\_\_\_\_  
(Address) \_\_\_\_\_
- My child's dental provider: (Name) \_\_\_\_\_ (Phone) \_\_\_\_\_  
(Address) \_\_\_\_\_
- Other: (Name) \_\_\_\_\_ (Phone) \_\_\_\_\_  
(Address) \_\_\_\_\_

and the following staff member(s) of Bradford Elementary School:

- school counselor     school social worker     school nurse     principal     my child's teacher
- special educator/case manager     Other: (Names or positions) \_\_\_\_\_

to release to each other, as appropriate, information from the records of \_\_\_\_\_ DOB \_\_\_\_\_  
for the purpose/s of:

- design and/or implementation of appropriate educational services
- health care evaluation, treatment, or care
- mental health/psychological evaluation, treatment, or care
- dental evaluation, treatment or care
- other: \_\_\_\_\_

The following information from the records is to be released:

- scholastic performance
- developmental and/or social history
- psychological, neuropsychological, neurological, and/or psychiatric evaluation/s
- progress, treatment, intake and discharge summary/ies (please check this if your child is seeing a counselor)
- medical history and evaluation/s
- dental history and evaluations
- other: \_\_\_\_\_

I understand:

- \* that state and federal laws protect the confidentiality of education and health information, and these records cannot be released to another party without my written permission, unless there are other state or federal laws that take away or limit this right.
- \* this Request For and Authorization To Release Information from my records, the nature of the records, their contents, and the consequences and implications of their release.
- \* that I may revoke this consent in writing to both parties named herein at any time within the school year except to the extent that action based on this consent has been taken. This consent will automatically expire at the close of the school year.

This request is voluntary on my part. I authorize the parties above to communicate by telephone, in person, by mail, fax, or e-mail concerning the above referenced purpose.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Printed Name: \_\_\_\_\_

- custodial parent     guardian     authorized representative