CYPRESS SCHOOL DISTRICT

AUTHORIZATION FOR RELEASE AND EXCHANGE OF INFORMATION

For use and/or disclosure of medical, mental health and/or educational information

Student Name: _____ Date of Birth: _____

I authorize the following individual(s) and/or organization(s) to release and exchange the above named individual's general health and/or mental health and/or educational information as described below:

Agency One:

☐ Cypress School District
☐ Other: _____
Individual(s) or Organization Name

Agency Two:

☐ Student's Physician(s) ☐ Regional Center
☐ Western Youth Services ☐ Phoenix House
☐ Other: _____
Individual(s) or Organization Name
☐

_____
Agency Contact Information (Phone/Email/Fax)

Duration:
This authorization shall become effective immediately and shall remain effective until _____. If no date is entered, the authorization shall remain in effect for as long as the student is enrolled in the Cypress School District.

Revocation:
I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to the organization 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 released in response to this authorization.

Redisclosure:
I understand that medical and/or educational information used or disclosed under this authorization may be subject to the recipient's redisclosure. It will 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). Information about my child and family is confidential. Our rights are persevered under Title 34 Code of Federal Regulations 300.154; Family Education Rights Privacy Act of 1974, Title 20 of the United States Code, Section 1232(g), Title 34 Code of Federal Regulations, Section 99.

Health Information:
I understand authorizing this disclosure of health information is voluntary. I can refuse to sign this authorization. I do not need to sign this form to assure medical treatment.

Purpose of Request: ☐ Educational Assessment/Planning ☐ Medical Practitioner ☐ 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. I understand that I may refuse to sign this consent form.

_____ _____ _____
Parent/Guardian Signature Relationship to Student Date

To revoke any authorization granted herein, send written notification to:
Cypress School District
5816 Corporate Ave., Suite 100
Cypress, CA 90630