



LYNWOOD UNIFIED SCHOOL DISTRICT
11321 Bullis Road, Lynwood, CA 90262
Phone (310) 886-1600 (X8139) / Fax (310) 639-6096

AUTHORIZATION FOR USE AND/OR DISCLOSURE OF MEDICAL AND/OR EDUCATIONAL INFORMATION

A. STUDENT/PATIENT INFORMATION

Student's Name (Last, First): _____ Date of Birth: _____ Sex: ☐ Female ☐ Male
Address: _____ City: _____ CA Zip: _____
Current School of Attendance: _____ Student ID Number: _____

B. I AUTHORIZE THE FOLLOWING INFORMATION TO BE RELEASED FROM THE FOLLOWING: _____
INITIAL

☐ Health Care Provider / Clinic / Other: _____
Phone Number/s: _____ Medical Record #: _____
☐ Health Care Provider / Clinic / Other: _____
Phone Number/s: _____ Medical Record #: _____

C. INFORMATION TO BE RELEASED TO AND USED BY THE LYNWOOD UNIFIED SCHOOL DISTRICT

Contact Person: _____ Title: _____ Phone Number: 310-886-1600
School / Department: Special Education Address: 11321 Bullis Road, Lynwood, CA 90262 Fax Number: (310)639-6096
E-Mail Address: _____

D. PURPOSE OF THE REQUESTED INFORMATION:

☐ Assist in determining most appropriate school education program/learning accommodations
☐ Assist in providing medical care during the school day
☐ Other: _____

E. TYPE/DESCRIPTION OF INFORMATION REQUESTED:

☐ Medical information	☐ Medication history	☐ Medication/s (current)
☐ Return to School (absence)	☐ Treatment Plans	☐ Recommendation for school
☐ Mental health	☐ Diagnosis	☐ Disease-specific information
☐ Relevant lab results	☐ Vaccination records	☐ Drug/Alcohol information
☐ Rating forms	☐ Behavioral concerns	☐ Other _____

F. SIGNATURE AUTHORIZING RELEASE OF INFORMATION:

The signature below certifies the above is true and correct. I understand that the information released may include information regarding treatment, hospitalization or outpatient care, including psychological/psychiatric impairment, drug abuse, alcoholism, AIDS, or HIV tests, and gives the requester permission to communicate with the health care provider, unless otherwise excluded here: _____

I also understand that the school district is responsible for maintaining confidential files for access and review only by involved educational staff. Academic, psychological, and health records are exchanged among California public schools.

I have read and understand the "Authorization Restrictions and Rights" form. Unless revoked, this authorization will expire in one (1) year, unless otherwise specified here:

Name of Parent/Guardian (Please print) _____ Date _____

Relationship to Student/Patient _____ Cell Number () _____

Signature of Parent/Guardian _____ Home/Work Number () _____