PANAMA-BUENA VISTA UNION SCHOOL DISTRICT
HEALTH, SAFETY & WELLNESS
4200 Ashe Road; Bakersfield, CA 93313
(661) 831-8331 ext 6286 FAX: 832-8002

Attachment E

AUTHORIZATION FOR RELEASE OF CONFIDENTIAL INFORMATION

REGARDING:
Student Name: _____ **Birthdate:**_____

Parent/Guardian Name(s): _____

Completion of this document authorizes the disclosure and/or use of individually identifiable health information, as set forth below, consistent with Federal laws (including HIPAA) concerning the privacy of such information. This information is being requested by the Panama-Buena Vista Union School District to assist in the educational planning for the above identified student. These records will become part of the school/educational records maintained by the school district as confidential files:

DURATION: This request will remain in effect for one (1) year from dated signature of parent and will allow the exchange of information between the following listed care provider(s) and the **Panama-Buena Vista Union School District** to facilitate the educational planning for this student.

RESTRICTIONS: Law prohibits the Requestor (School District) from making further disclosure of my health information unless the Requestor obtains another authorization form from me or unless such disclosure is specifically required or permitted by law.

REVOCATION: I may revoke this Release at any time. My revocation must be in writing, signed by me or on my behalf, and delivered to the health care agencies/persons listed below. My revocation will be effective upon receipt, but will not be effective to the extent that the Requestor or others have acted in reliance to this Release.

RE-DISCLOSURE: I understand that the Requestor will protect this information as prescribed by the Family Educational Rights and Privacy Act (FERPA) and that the information becomes part of the student's educational record. The information will be shared with individuals working at or with the School District for the purpose of providing safe, appropriate, and least restrictive educational settings, and school health services and programs.

Agency/Person/Organization	Address	Phone	FAX

Information Requested: ❑ Educational ❑ Psychological ❑ Health/Medical ❑ Treatment Plan
❑ Diagnosis ❑ Other _____

Please include evaluations and records from _____ to _____
(Date) *(Date)*

If this student has a diagnosed health condition, please include student's diagnosed condition(s) and information as to whether the condition affects student's strength, vitality, or alertness and all health care services required.

Send information to: **Panama-Buena Vista Union School District**
Health, Safety & Wellness
4200 Ashe Road, Bakersfield, CA 93313

Attention: _____

Title: _____

I have read and agree to the terms and nature of this Release. I understand that signing this Release is voluntary. My child's participation in regular education, IDEA or Section 504, or services and programs, will not be conditioned upon my authorization of this disclosure.

Parent/Guardian Signature:_____ **Date:**_____