TRACY UNIFIED SCHOOL DISTRICT

1875 West Lowell Avenue
Tracy, CA 95376

Rob Pecot, Superintendent

Jason Davis, Director of Special Education
Julie Wimberley, Program Administrator
Phone 209-830-3270
FAX: 209-830-3274

AUTHORIZATION FOR EXCHANGE OR DISCLOSURE OF HEALTH/SCHOOL INFORMATION

Completion of this document authorizes the exchange or disclosure and/or use of individually identifiable information as set forth below, consistent with the California and Federal laws concerning the privacy of such information.

Student Name: ____ ______________
Last First MI Date of Birth

I, the undersigned, do hereby authorize:

________________________ __________________________________ __________ ____
Agency/Provider Name Address City State

____
Medical Record # (if applicable

To exchange information and records regarding the above named patients/students with:

Tracy Joint Unified School District, 1875 W. Lowell Avenue, Tracy, CA 95376
Please send records indicated below to:

Attention: ___________________________ ________________________________
Name Title

The disclosure of information is required for the following purpose:

- ☐ Educational Assessment
- ☐ Educational Planning
- ☐ Initiated by request of parent/legal guardian
- ☐ Other: ______________________

Requested information:

- ☐ All health information
- ☐ Psychological
- ☐ All Education (incl Special Education) Records
- ☐ Discharge Summary
- ☐ Immunization Records
- ☐ Consultation reports
- ☐ OT / Speech Reports
- ☐ Other: ________________________________

Duration: This authorization shall become effective immediately and shall remain in effect until one year from the date of signature if no date is specified.

Revocation: I understand that I have the right to revoke this authorization in writing at any time by sending such written notification to the releasing agency. 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 the requestor (TJUSD) will protect this information as prescribed by the Family Equal Rights Protection Act (FERPA) and that the information becomes part of the student's permanent educational record. The information will be shared with individuals working at or with TJUSD for the purpose of providing a safe, appropriate and least restrictive educational setting and school health services programs.

I understand that authorizing the disclosure of health/educational information is voluntary and I have the right to receive a copy. A copy of this authorization is valid as the original.

Approval:

______________________ ____ ________
Print Name Signature Relationship Date

_________________________ ____________________ _______________ ________
Address City, Sate, Zip Phone Copy Received