



Colton Joint Unified School District

AUTHORIZATION TO USE AND EXCHANGE INFORMATION

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

Student's Name: _____ Date of Birth: _____ Gender: _____

Student's Address: _____

Authorizer's Name: _____ Relationship to Student: _____

INDIVIDUAL/AGENCY REQUESTING INFORMATION		INDIVIDUAL/AGENCY DISCLOSING INFORMATION	
ADDRESS		ADDRESS	
CITY, STATE, ZIP CODE		CITY, STATE, ZIP CODE	
TELEPHONE NUMBER	FAX NUMBER	TELEPHONE NUMBER	FAX NUMBER
EMAIL		EMAIL	

The following confidential information about or records of the student can be exchanged: Everything

Yes No

- Assessment Results
- Medical Diagnosis
- Mental Health Diagnosis
- STD/HIV Test Results
- Substance Abuse Information

Yes No

- Medication Information
- Medical Records
- Psychiatric Records
- Psychological Records
- Educational Records

Other information/records: _____

I want the information to be shared only for the following purpose(s):

- Educational assessment
- Eligibility determination
- Other: _____
- Service coordination and treatment planning
- Education planning

I want this information to be shared by the following means: (check all that apply)

- Written form
- In meetings or by phone
- Electronically
- Fax

This authorization shall become effective immediately and shall remain in effect until _____ or for one year from the date of signature if no date is entered. I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to the individual/agency disclosing the information. Written revocation will be effective upon receipt but will not apply to information that has already been released in response to this authorization.

I have a right to receive a copy of this Authorization. Signing this Authorization may be required in order for this student to obtain appropriate services in the educational setting.

Signature of Authorizing Person: _____ Date: _____