AUTHORIZATION FOR USE AND/OR DISCLOSURE OF INFORMATION

The use and distribution of this form is limited to employees of public school agencies within the Riverside County Special Education Local Plan Area (SELPA)

Student Name: _____ (First) _____ (Middle) _____ (Last) __/__/____ (Birthdate)

_____ (Students Address) _____ (Medical Record Number (if applicable)) (___) ___ - _____ (Phone Number) (___) ___ - _____ (Alternate Phone Number)

I AUTHORIZE THE FOLLOWING INDIVIDUAL OR ORGANIZATION TO DISCLOSE THE ABOVE NAMED INDIVIDUAL'S MEDICAL/EDUCATIONAL INFORMATION AS DESCRIBED BELOW

☐ Receiving ☐ Disclosing Party	☐ Receiving ☐ Disclosing Party
Individual or Organization	Beth Marler, RN- District Nurse **Individual or Organization**
	Temescal Canyon High School
Address	28755 El Toro Rd. **Address**
City, State, Zip Code	Lake Elsinore, CA 92532 **City, State, Zip Code**
(___) ___ - _____ **Telephone**	(951) 253 - 7250 **Telephone**
(___) ___ - _____ **Fax**	(951) 253 - 7277 **Fax**

Duration: 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.

Revocation: I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to the disclosing 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 medical/educational information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and 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).

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

Specify Record(s): Indicate type of information is to be disclosed:

☐ **Educational** ☐ **Educational Mental Health** ☐ **Medication** ☐ **Drug/Alcohol**
☐ **Medical** ☐ **Clinical Mental Health** ☐ **Psychiatric** ☐ **Other:**

Any and all information with regard to the above records may be released except as specifically provided here:
Qualification for consideration of education services is dependent upon a qualifying diagnosis by the disclosing party.
I request that the information released pursuant to this authorization be used for the following purposes only:

☐ **Educational Assessment** ☐ **Educational Planning** ☐ **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 request to inspect or obtain a copy of the information to be used or disclosed.

_____ *Signature of Student(18 years or older) or Student's Representative* _____ *Description of Relationship to Student* __/__/____ *Date*

_____ *Signature of Student (12 years or older) when requesting medical, clinical mental health, medication and/or psychiatric records* __/__/____ *Date*