AUTHORIZATION FOR EXCHANGE OF INFORMATION

____
Date of Request

_______________________________ _______________________________
Name of Student | Date of Birth

_______________________________ _______________ _______________
Address of Student | Phone Number | Other Phone Number

____
City | State | Zip

I hereby authorize the following individual or organization to disclose the above named individual's educational and/or medical information as described below:

_______________________________ _______________________________
Name of Disclosing Party | Name of Recipient

_______________________________ _______________________________
Address | Address

_______________________________ _______________________________
City | State | Zip | City | State | Zip

_______________________________ _______________________________
Phone Number | Phone Number

Duration: This authorization shall become effective immediately and shall remain in effect for one (1) year from the date of signature unless a different date is specified here :____________________(date).

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 party. Written revocation will be effective upon receipt, but will not apply to information that has already been released in response to this authorization, and except to the extent that the disclosing party or others have acted in reliance upon this authorization.

Re-disclosure: I understand that the recipient may not lawfully further use or disclose the health information unless another authorization is obtained from me or unless such use of disclosure is specifically required or permitted by law. Confidentiality of student information is maintained according to California Welfare and Institutions Code Section 4514; Education Code Section 49075; and the Family Educational Rights and Privacy Act of 1974, 20 U.S.C. Section 1232g (FERPA).

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

☐ Educational ☐ Medical ☐ Medication ☐ Psychiatric

☐ Mental Health ☐ Vision ☐ Drug/Alcohol ☐ STD/HIV Test Results

☐ Audiological ☐ Other: ___________________________

I request that the information released pursuant to this authorization be used for the following purposes only:

☐ Educational Assessment ☐ Educational Planning ☐ Other: ____________________

____ ____
Signature of Parent/Guardian Date

____ ____
Signature of Witness Date

A copy of this authorization is as valid as the original.
Parent/guardian has the right to a copy of this authorization.