Jefferson Union High School District
AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH 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., HIPPA, FERPA) concerning the privacy of such information. Failure to provide all information requested may invalidate this authorization.

USE AND DISCLOSURE INFORMATION

_____

Student's Name (Last) (First) (MI) (Date of Birth)

I, the undersigned, do hereby authorize the following (physician(s) name(s) in the spaces below) to provide health information for the above-named student/child's medical/health record to and from the school site and district contact person listed.

_____

(Physician Name) (Phone)

_____

(Physician Address)

*Disclosure of health information is required for the following purpose:*_____

_____

_____

Requested information shall be limited to the following:

☐ All minimum necessary health information OR

☐ Disease/Illness Specific Information as described:_____

_____

_____

(School Site to Which Disclosure is Made) (Phone)

*(District Nurse)*_____

(Contact Person at School District) (Address)

DURATION

This authorization shall become effective immediately and shall remain in effect for **one year** from the date signed **OR** until the following date:_____.

RESTRICTIONS

California law prohibits the Requestor from making further disclosure of my health information unless the Requestor obtains another form from me or unless such disclosure is specifically required or permitted by law.

PARENT/GUARDIAN RIGHTS

I understand that I have the following rights with respect to this Authorization:

- I may revoke this Authorization at ANY time.
- My revocation must be in writing, signed by me or on my behalf, and delivered to the healthcare provider/agency/plan Listed above.
- I have the right to review records.
- I have a right to receive a copy of this Authorization.

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STUDENT RIGHTS

Students between the ages of 12 and 18 years must sign this form in order to approve the disclosure of information relating to mental health and family planning issues.

RE-DISCLOSURE

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

I understand that signing this Authorization may be required in order for my student/child to obtain appropriate services and Support in the educational setting.

APPROVAL

_____	_____	_____
(Parent Printed Name)	*(Parent Signature)*	*(Date)*
_____	_____	
(Relationship to Student/Child)	*(Phone)*	
_____	_____	_____
(Student Printed Name)	*(Student Signature)*	*(Date)*