AUTHORIZATION FOR USE AND/OR DISCLOSURE OF MEDICAL AND/OR EDUCATIONAL INFORMATION

Student's Name _____ Sex _____ Birth Date _____

Parents/Guardian Name _____ School _____ Grade _____

Street Address _____ Apartment # _____ Home Phone _____

City _____ State _____ Zip _____ Business Phone _____

I authorize the Conejo Valley Unified School District to:

☐ **Release to** ☐ **Request information pertaining to the above named individual as described below:**

Individual or Organization Disclosing/Receiving Information:	Individual or Organization Disclosing/Receiving Information:
CVUSD – _____ (School / Dept.) Name _____ Address _____ City, State, Zip Code	_____ Name _____ Address _____ City, State, Zip Code

Duration: This authorization shall become effective immediately and shall remain in effect until _____(Date) or for one year from the date of signature if no date is entered.

Revocation: I understand that I have the right to revoke the 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 health information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and it is no longer 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 under the Family Educational Rights and Privacy Act (FERPA).

Health Information: I understand that authorizing the disclosure of health information is voluntary. I can refuse to sign the authorization.

Specify Record(s): Indicate type of information to be disclosed**:** ☐ **Medical Information** ☐ **Medication Information** ☐ **Mental Health** ☐ **Psychological or Counseling Information** ☐ **Educational Records** ☐ **Other:** _____

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.

_____ _____ _____

Parent/Guardian Signature Relationship to Student Date

Person requesting records: _____

Distribution: ☐ **District Office** ☐ **Appropriate Individual/Agency** ☐ **Cumulative Folder**