SACRAMENTO CITY UNIFIED SCHOOL DISTRICT
5735 47TH Avenue
Sacramento, CA 95824

AUTHORIZATION FOR USE AND/OR DISCLOSURE OF INFORMATION

Name of Student (list other names used)	*Medical Record Number (if applicable)*	*Date of Birth*
Address of Student	*Phone Number*	*Other Phone Number*

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

Individual or Organization Disclosing Information:

Disclosing Party

Address

City, State, Zip Code

Phone Number *Fax Number*

Individual or Organization Receiving Information:

Receiving Party

Address

City, State, Zip Code

Phone Number *Fax Number*

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 this 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 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 that is to be disclosed:

☐ Medical Information ☐ Medication Information ☐ Psychiatric Information ☐ Mental Health

☐ Drug/Alcohol Information ☐ STD/HIV Test Results ☐ Education Records

☐ Other:

I request that the information released pursuant to this authorization to 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.

Signature of Student or Student's Representative	*Description of Relationship to Student*	*Date*

This document is confidential and may not be shared with third parties without written parental consent unless the disclosure meets one of the exceptions to FERPA's general consent requirement. (See 34 CFT §§ 99 et seq.)