PITTSBURG UNIFIED SCHOOL DISTRICT

Office of Student Services
Dr. ReJois Frazier-Myers, Director
2000 Railroad Ave, Suite D ▪ Pittsburg, CA 94565
(925) 473-2347 ▪ Fax (925) 439-1650

RELEASE OF STUDENT INFORMATION AUTHORIZATION

THIS FORM MUST BE COMPLETELY FILLED OUT BEFORE REQUESTING PARENT SIGNATURE
Do not leave areas blank. Mark n/a where appropriate.

_____ _____ _____
Name of Student (list other names used) School of Attendance Date of Birth

_____ _____ _____
Address of Student Phone No. Other Phone No.

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

Individual or Organization <u>Disclosing</u> Information:	**Individual or Organization <u>Receiving</u> Information:**
Address	Address
City State Zip	City State Zip
Telephone Fax	Telephone Fax

Duration: This authorization shall become effective immediately and shall remain in effect until _____ (date) or for one year from the date of signature if not 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.

Re-disclosure: I understand that health information used or disclosed pursuant to this authorization may be subject to re-disclosure 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 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 what type of information is to be disclosed:

❒ Educational Records ❒ Special Education Records/Assessments
❒ Medical/Medication Information: Medical record # _____ ❒ Mental Health
❒ Other: Specify _____

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

❒ Educational Assessment ❒ Educational Planning ❒ Other: _____

A copy of this authorization is as valid as the original. I understand that I have a right to receive a copy of this authorization for my records.

_____ _____ _____
Date Signature of Parent or Legal Guardian Relationship to Student

Transmission of this information to individuals or agencies not listed is prohibited without written consent. (E.C. 49075)
Note: this authorization is to be made a permanent part of the student's record in accordance with State and Federal regulations.