Rosemead School District
Special Education & Student Support Services
3907 Rosemead Blvd.
Rosemead, CA 91770

Phone: (626) 312-2900, ext. 230
Fax: (626) 312-2913

AUTHORIZATION FOR USE AND/OR DISCLOSURE OF INFORMATION

Name of Student:	Date of Birth:	Medical Record Number (if applicable):

Address:	Phone No.:	Other Phone No.:

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

Individual or organization releasing information:

Name:	
Address:	
Phone Number:	
Fax Number:	
Email:	

Individual or organization receiving information:

Rosemead School District
3907 Rosemead Blvd.
Rosemead, CA 91770
Phone: (626) 312-2900, ext. 230
Fax: (626) 312-2913

Please release the following information:

☐ Medical ☐ Educational Records ☐ Mental Health
☐ Drug/Alcohol Information ☐ Psychiatric Information ☐ Other _____

This information will be used for the purpose of:

☐ Educational Assessment ☐ Educational Planning ☐ Other: _____

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 and I do not need to sign this form in order to assure medical treatment.

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 *Relationship to Student* *Date*