American Academy of Pediatrics

DEDICATED TO THE HEALTH OF ALL CHILDREN™

California Chapter 4

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

Affix Patient Stamp or Complete Information

Name of Student/Child_____

Date of Birth_____

Address of Student/Child_____

City, State, Zip Code_____

☐ ***I authorize the following individual or organization to disclose the above named individual's health/education/school information as described below:***

Individual/Health Care Provider: ☐Disclosing Information ☐Receiving Information ☐Disclosure and Receiving

☐School/Education Program Receiving Information

Disclosing party_____

Address_____

City, State, Zip Code_____

Telephone_____

Receiving Party_____

Address_____

City, State, Zip Code_____

Telephone_____

☐ ***I give permission for <u>both</u> parties identified above to disclose and receive this information***

Duration: This authorization shall become effective immediately and shall remain 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 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 a public educational agency is protected as a student record under the Family Education 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: Indicate type of information to be disclosed:

☐ Medical Information	☐ Medication History	☐ Medications (current)
☐ Return to school (absence)	☐ Treatment plans	☐ Recommendations for school
☐ Mental Health	☐ Diagnosis	☐ Disease-specific information
☐ Relevant Lab Results	☐ Vaccination Records	☐ Drug/Alcohol Information
☐ Rating Forms	☐ Behavioral Concerns	☐ Other _____

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

☐ ***Health Assessment***	☐ ***Educational Planning***
☐ ***Medical Management***	☐ ***Other_____***

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

_____

Student/Child's Parent/Guardian/Representative Signature

_____

Description of Relationship to Child ***Date***

Bold Italics lettering (14 font)– to be complete by parent/guardian/representative