



WESTERN PLACER UNIFIED SCHOOL DISTRICT
AUTHORIZATION FOR EXCHANGE OF INFORMATION
MEDICAL

Date of this request: ___/___/___

I hereby authorize:

To disclose to and/or receive information from:

Name
Name of organization
Address
City State Zip
Phone Fax

Name of Recipient
Name of organization
Address
City State Zip
Phone Fax

Information Pertaining to:

Student's Name: _____ Date of Birth: ___/___/___

This authorization applies to the following information:

- All health information pertaining to any medical history, mental or physical condition and treatment received. [Optional] Except: _____
Only the following records or types of health information (including any dates): _____

The recipient may use the health information authorized on this form for the following purposes:

Date(s) of treatment:

Duration: This authorization shall become effective immediately and shall remain in effect for one year from the date of signature unless a different date is specified here: ___/___/___ (date).

Revocation: This authorization is also subject to written revocation by the parent/guardian at any time. The written revocation will be effective upon receipt, except to the extent that the disclosing party or others have acted in reliance upon this authorization.

Re-disclosure: I understand that the recipient may not lawfully further use or disclose the health information unless another authorization is obtained from me or unless such use of disclosure is specifically required or permitted by law. Confidentiality of student is maintained according to California Welfare Institute Code, Section 4514; and Education Code, Section 49075: "A school district may permit access to pupil records to any person for whom a parent of the pupil has given written consent specifying the records to be released and identifying the party or class of parties to whom the records may be released. The recipient must be notified that the transmission of information to others without the written consent of the parent is prohibited. The consent shall be permanently kept with the record file."

Parent/Guardian _____ Date ___/___/___ Time _____

Witness Signature

A copy of this authorization is as valid as the original. Parent or guardian has the right to a copy of this authorization.

The Federal Family Rights and Privacy Act of 1974 and California Law do not require parent permission for the transfer of student's records between school districts.