No Facsimiles will be Accepted for Release of Medical Information

WARNER UNIFIED SCHOOL DISTRICT
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 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 Disclosing Information:	**Individual or Organization Receiving Information:**
Warner Unified School District *Disclosing party*	*Receiving Party*
30951 Hwy 79 *Address*	*Address*
Warner Springs, CA 92086 *City, State, Zip Code*	*City, State, Zip Code*
Telephone: 760-782-3517 *FAX:* 760-782-9117 Not valid for medical information	*Telephone:* _____ *FAX:* _____ Not valid for medical information

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.

FERPA: I 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.

Specify Record(s): Indicate type of information to be disclosed:

- ☐ **Medical**
- ☐ **Medication**
- ☐ **Psychiatric**
- ☐ **Mental Health**
- ☐ **Drug/Alcohol**
- ☐ **STD/HIV Test Results**
- ☒ **Educational**
- ☒ **Other:** Attendance

Any and all information with regard to the above records may be released except as specifically provided here:

_____

_____

I request that the information released pursuant to this authorization 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*