



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

Name of Student (list other names used)	Medical Record No. (if applicable)	Date of Birth
Address of Student	Phone Number	Other Phone No.

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

Organization/Individual	Organization/Individual
Organization/Name	Organization/Name
Address	Address
City, State, Zip Code	City, State, Zip Code
Telephone No.	Telephone No.

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 have 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 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. 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 Information
- Medication Information
- Psychological Information
- Speech/Language Assessment
- Occupational/Physical Therapy Assessment
- Educational Records
- Other: _____

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.

X _____

Signature of Student or Student's Representative	Description of Relationship to Student	Date
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