DJUSD
DAVIS JOINT UNIFIED SCHOOL DISTRICT

John A. Bowes, Ed.D.
Superintendent

526 B Street ◆ Davis, CA 95616 ◆ (530) 757-5300 ◆ FAX: (530) 757-5323 ◆ www.djusd.net

Authorization for Release of Health and Education Information

Referring Staff: _____Phone: _____ Referral Date: _____

Email: _____ Fax Number: _____

I. THE PATIENT/STUDENT WHOSE EDUCATIONAL/PROTECTED HEALTH INFORMATION IS BEING REQUESTED

Student/Patient Name: _____DOB: _____/____/___ Age:_____

Address: _____Phone: _____

School Attending: _____

Sex: ☐M ☐F ☐Other

II. THE HEALTH CARE PROVIDER/INDIVIDUAL/ENTITY AUTHORIZED TO MAKE THE DISCLOSURE TO DJUSD

Name of Provider/Individual/Entity: _____

Address: _____

Phone: _____Fax: _____

III. THE INFORMATION TO BE DISCLOSED CONCERNING THE PATIENT/STUDENT:

- ☐ Diagnoses
- ☐ Medical, Health, and/or Hospital Care, Testing, Evaluation, & Treatment
- ☐ Medications Prescribed, Including But Not Limited to Prescription Refill Sheets
- ☐ Psychological, Psychiatric, Mental Health Care, Testing, Evaluation, & Treatment
- ☐ Drug and Alcohol Treatment
- ☐ Educational Records, Plans, Evaluations, & Treatment/Treatment Plan
- ☐ Other: (Describe)

_____

This information will be used for the sole purpose of aiding the Davis Joint Unified School District (DJUSD) in determining the nature and extent of appropriate educational programming, services, and accommodations for the Student.

III. ACKNOWLEDGEMENTS

By signing below, Parent/Guardian/Adult Student acknowledges that:

Refusing to sign this Authorization will not affect DJUSD's responsibility to provide an appropriate education for your child. Your child's health care and treatment will not be conditioned on whether you sign this authorization. However, without the proper educational/health information, DJUSD may not be aware of important information that is relevant to the provision of appropriate educational services to your child.

This Authorization may be revoked at any time by providing DJUSD and the Health Care Provider/Individual/Entity with a written request to revoke this Authorization. You understand that a signed revocation is not effective to the extent that any person or entity has already acted in reliance on your authorization before your revocation was received.

DJUSD and many other organizations and individuals such as physicians, hospitals and health plans are required by law to keep your child's educational/health information confidential. If you authorize the disclosure of your child's educational/health information to a person or entity that is not legally required to keep it confidential, the information may be re-disclosed and may no longer be protected by state/federal law.

A photocopy, scanned, or fax copy of this Authorization is as valid as the original.

You have a right to receive a signed copy of this Authorization. If you do not receive a copy, please contact DJUSD to obtain your copy.

IV. AUTHORIZATION

I hereby authorize the disclosure, use and exchange of the above information, which may include protected health and medical information, between _____ (Health Care Provider/Individual/Entity) and DJUSD staff, including DJUSD contract service providers, concerning the above named student/patient. This authorization shall apply to protected health and medical information that is governed by the Health Insurance Portability and Accountability Act (HIPAA) and California law. This information is confidential and may not be given to employees of other schools, public agencies, or individual professionals in private practice without my consent; unless another authorization is obtained from me or unless such use or release is specifically required or permitted by law.

The authorization shall be valid until _____/_____/_____. You may provide a date after which no information can be released. If no date is provided, authorization is valid for <u>one year</u> from the date of signature. This consent is voluntary and may be revoked at any time.

Parent/Guardian Name Printed (Student if over 18): _____

Parent/Guardian Signature (Student if over 18): _____Date: _____

PLEASE COMPLETE AND RETURN TO THE REFERRING STAFF MEMBER IDENTIFIED ON THE FRONT OF THE FORM

This authorization conforms to the requirements of the California Civil Code, HIPAA, FERPA, IDEA, and corresponding laws and regulations.

For Official Use Only
Date Received Complete Form: _____/_____/_____ Initials: _____