EAST SIDE UNION HIGH SCHOOL DISTRICT

AUTHORIZATION FOR EXCHANGE OF STUDENT HEALTH AND EDUCATION INFORMATION

I GIVE PERMISSION TO:

_____

Name of person or organization allowed to release information

_____

Address City State Zip

TO RELEASE INFORMATION TO AND/OR RECEIVE INGORMATION FROM:
East Side Union High School District _____

Name of Student's School Telephone

_____

Address City State Zip

PERTAINING TO:

_____

Name of Student Medical Record# Date of Birth

_____

Address, City, State, Zip Telephone

DURATION: This authorization shall become effective immediately and shall remain in effect for one year from the sate of signature unless a different date is specified here ____/____/____.
CANCELLATION: This Authorization is also subject to written cancellation by the parent/guardian/student at any time. The written cancellation will be effective upon receipt. Cancellation will not apply to actions taken based on information obtained from prior authorization(s).
RE-RELEASE: I understand that the recipient may not lawfully further use or release the information unless another authorization is obtained from me or unless such use or release is specifically required or permitted by law.
CONDITIONS: I understand that eligibility for educational services may be based on my giving or refusing to give this authorization. Federal Register Section 164.508(c)(2)(ii).
SPECIFIC RECORDS: Check the box and initial which type of information is to be release.

Initial_____ _ Immunizations	Initial_____ _ Health & Developmental
Initial_____ _ Educational	Initial_____ _ Hearing/Audiological
Initial_____ _ Speech & Language	Initial_____ _ Birth Records
Initial_____ _ Medical Information	_____ _ Mother's Maiden Name
Initial_____ _ Vision	Initial_____ _ Other (Specify:_____)

The person or organization who receives the health and/or educational information authorized on this form, may use it for the following educational purpose:
_ Eligibility _ Planning _ Health Services _ Other (Specify:_____)

Parent/Guardian or Student will receive a copy of this authorization.

Date: ____/____/____. Signature: _____
If signed by other than student, indicate relationship: _ Mother _ Father _ Guardian