Tehama County
Special Education Local Plan Area

A Cooperative Activity of the County's School Districts and Department of Education

Authorization for Release of Health Information

A. STUDENT/PATIENT INFORMATION

Name: _____
LAST FIRST MI

Date of Birth: _____ Sex: M F Student ID#: _____

B. INFORMATION TO BE RELEASED FROM:

___ _____ School District
___ California Children's Services (CCS)
___ CCS Medical Therapy Unit
___ St. Elizabeth Community Hospital
___ Mercy Medical Center, Redding
___ Tehama Co. Public Health
___ Tehama Co.Dept. of Education
___ Tehama Co. Health Center
___ Tehama Family Fitness Center
___ U.C. Davis Medical Center
___ Lassen Medical Group, Red Bluff
___ Redding Medical Center
___ Lassen Medical Group, Corning
___ Far Northern Regional Center
___ Tehama Co. Mental Health
___ Tehama Co. Drug & Alcohol

___ Physician/Clinic/Other: _____

___ Physician/Clinic/Other: _____

C. INFORMATION TO BE RELEASED TO AND USED BY _____ SCHOOL DISTRICT:

School/Department: _____ Contact Person: _____

Address _____ City _____ State _____ Zip _____

Phone: _____ Fax: _____

D. PURPOSE OF THE REQUESTED INFORMATION

___ Authorization forwarded at the request of Parent / Legal Guardian
___ Assist in determining most appropriate school education program / learning accommodations
___ Other: _____

E. TYPE/DESCRIPTION OF INFORMATION REQUESTED

___ Immunization Record
___ Physician Orders
___ History and Physical
___ Consultation Reports
___ Operative Reports
___ Lab Results / X-ray Reports
___ Discharge Summary
___ Other: _____
___ Ambulatory Clinic Summary
___ Appointment Dates/Times
___ Mental Health Records

F. SIGNATURE AUTHORIZING RELEASE OF INFORMATION

By signing below, I understand that the information released may include information regarding treatment, hospitalization, or outpatient care, including psychological/psychiatric impairment, drug abuse, alcoholism, AIDS, or HIV tests, unless otherwise excluded here: _____

I also understand that the school district is responsible for maintaining confidential files for access and review by involved educational staff only. Academic, psychological and health records are exchanged among California public schools.

I have read and understand the "Authorization Restrictions and Rights" on the backside of this form which includes my right to refuse to sign this authorization, to revoke this authorization, and to receive a copy of this authorization.

Unless revoked, this authorization will expire in 1 year, unless otherwise specified here: _____

_____ _____
Signature of Parent / Legal Guardian **Date**

_____ _____
Signature of Witness **Date**