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SWEETWATER
UNION HIGH SCHOOL DISTRICT

STUDENT HEALTH SERVICES
1130 5TH AVENUE CHULA VISTA, CA 91911
TELEPHONE: (619) 585- 6020 ▲ FAX: 407-4982

AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION TO SCHOOL DISTRICTS

Completion of this document authorizes the disclosure and/or use of individually identifiable health information, as set forth below, consistent with California and Federal laws (e.g., HIPAA) concerning the privacy of such information. Failure to provide all information requested may invalidate this authorization.

USE AND DISCLOSURE INFORMATION:

Patient/Student Name: _____ _____ _____ _____
Last First MI Date of Birth

I, the undersigned, do hereby authorize (name of agency and/or health care providers):

(1) _____ (2) _____
Phone Number Phone Number

to provide health information from the above-named child's medical record to and from:

_____ _____
School District to Which Disclosure is Made Address / City and State / Zip Code

_____ _____
Contact Person at School District Area Code and Telephone Number

The disclosure of health information is required for the following purpose:

_____

Requested information shall be limited to the following: ☐ All minimum necessary health information; **or** ☐
Disease-specific information as described:

_____

DURATION:
This authorization shall become effective immediately and shall remain in effect until _____ (enter date) or for one year from the date of signature, if no date entered.

RESTRICTIONS:
California law prohibits the Requester from making further disclosure of my health information unless the Requester obtains another authorization form from me or unless such disclosure is specifically required or permitted by law.

YOUR RIGHTS:
I understand that I have the following rights with respect to this Authorization: *I may revoke this Authorization at any time.* My revocation must be *signed* by me or on *my behalf,* and *delivered* to the health care *agencies/persons* listed above. My revocation will be effective upon receipt, but will not be effective to the extent that the Requestor or others have acted in reliance to this Authorization.

RE-DISCLOSURE:
I understand that the Requestor (Sweetwater Union High School DIstrict) will protect this information as prescribed by the Family Educational Rights and Privacy Act (FERPA) and that the information becomes part of the student's mandatory interim education record. The information will be shared with individuals working at or with the School District for the purpose of providing safe, appropriate, and least restrictive educational settings and school health services and programs.

I have the right to receive a copy of this Authorization. Signing this Authorization may be required in order for this student to obtain apprrpriate services in the educational setting.

APPROVAL:

_____ _____ _____
Printed Name Signature Date

_____ _____
Relationship to Patient/Student Area Code and Telephone Number

The Sweetwater Union High School District does not discriminate with regard to sex, sexual orientation, gender, ethnic group identification, race, ancestry, national origin, religion, color, mental disability, or physical disability, age, marital or parental status or any other unlawful consideration."
SUHSD Board Policy #2224

Copy: File
Psychologist
Parent