Palermo Union School District

AUTHORIZATION FOR EXCHANGE OF CONFIDENTIAL INFORMATION

To: Physician's name: _____

Address: _____

Phone number: _____ Fax number: _____

Parent/Guardian Authorization:

This authorization shall remain valid no longer than one year from the date of signature.
I hereby request and authorize the exchange of information and/or release of the following records pertaining to my child between you and professional staff of the Palermo Union School District. I understand that I have a right to receive a copy of this authorization. I have the right to refuse to sign this form, but I understand that medical verification is required for the Medical Independent Study/Home Hospital Instruction Program. I understand that I may revoke or modify this consent at any time by providing written notice. Written revocation will be effective upon receipt but will not apply to information that has already been released in response to this authorization. I understand that this health information used or disclosed pursuant to this authorization may be subject to the re-disclosure by the recipient, and it 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).

Print name: _____ Signature: _____

Date: _____

STUDENT DATA: Student's Name: _____ Birthdate: _____

Student's Home School: _____ Grade: _____

Medical Provider: _____

Medical Identification Number: _____

INFORMATION AND/OR RECORDS REQUIRED: Disclosure of information shall be limited to medical background of diagnosed condition as it pertains to the request for Medical Independent Study (MIS) or Home Hospital Instruction (HHI).

PURPOSE FOR WHICH INFORMATION IS NEEDED: To plan and implement a relevant education program for the student.

RETURN TO: Anne Hays, PUSD Health Programs
7390 Bulldog Way, CA 95968
Phone: (530) 533-4842 Fax: (530) 532-1047

PLEASE NOTE: If your student's medical provider requires an authorization for exchange of medical information other than the PUSD provided form, it is your responsibility to obtain, complete and submit it as part of your student's MIS/HHI application.