Nevada Joint Union High School District
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 law concerning the privacy of such information. Failure to provide all information requested may invalidate this authorization.

A. STUDENT/PATIENT INFORMATION

Name: _____
Last First MI

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

B. INFORMATION TO BE RELEASED FROM (3 AS NEEDED)

_____ _____ School District
_____ California Children's Services (CCS)
_____ Nevada County Behavioral Health
_____ Nevada County Community Health
_____ Physician / Clinic / Other:
_____ Address _____
_____ _____

_____ U .C. Davis Medical Center
_____ County Office of Education
_____ Other: _____
_____
_____

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_____ PT / OT
_____ Rehabilitation
_____ Special Clinics
_____ Speech & Hearing
_____ Other: _____

C. INFORMATION TO BE RELEASED TO AND USED BY PARK AVENUE ALTERNATIVE EDUCATION:

School / Department: Nursing Contact Person: Kris Youngman R.N.

Address: 140 Park Ave. City: Grass Valley State: Ca. Zip: 95945

Phone: 530-272-2635 ext. 317 Fax: 530-272-8564

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

_____ 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, health history, 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 reverse 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 one year, unless otherwise specified here: _____

_____ _____
Signature of Parent / Legal Guardian Date

_____ _____
Signature of Witness Date

Authorization Restrictions and Rights

- Signing the authorization is voluntary. You can refuse to sign this authorization. Refusing to sign this authorization will not affect this School District's commitment to providing a quality education for your child; however, refusing to sign may inhibit the school's ability to implement an optimal plan of education, learning accommodations and/or health care plan for your child.

- This authorization may be revoked at any time. To revoke this authorization, you must provide the organization or individual listed in Section B of this form, with a written request to revoke the authorization. Any information disclosed before your written revocation is received may be used as previously permitted.

- You have the right to receive a copy of your "Authorization for Use or Disclosure of Health Information to School Districts". If you request it, you will receive a copy of this authorization after you sign it.

- .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. No further disclosure of this information, by the School District, should be done without specific, written and informed release by parent/legal guardian.

- If you authorize disclosure of 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 or federal law.

- You may inspect or copy the information to be disclosed, as provided in CFR 164.524.