La Mesa-Spring Valley School District

Authorization For Use Or Disclosure Of Health Information

HIPAA Approved

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) _____

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

La Mesa-Spring Valley School District — *School or District to Which Disclosure is Made*

4750 Date Avenue, La Mesa, CA 91941 — *Address*

_____ — *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 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 Requestor from making further disclosure of my health information unless the Requestor 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 in writing, 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 (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 educational 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 appropriate services in the educational setting.

APPROVAL:

_____ *Printed Name* | _____ *Signature* | _____ *Date*

_____ *Relationship to Patient/Student* | _____ *Area code and Telephone number*