LEMOORE UNION HIGH SCHOOL DISTRICT

DEBBIE MURO
District Superintendent

CHARLES GENT
Assistant Superintendent
Curriculum & Instruction

5 Powell Avenue, Lemoore, CA 93245
(559) 924-6610 ~ FAX (559) 924-9212 ~ www.luhsd.k12.ca.us

AUTHORIZATION FOR USE AND/OR DISCLOSURE OF INFORMATION

____ Name of Student (list other names used)

_____________________ Date of Birth

____ Address of Student

____________________________________ Phone No. Other Phone No.

I authorize the following individual or organization to disclose the above named individual's medical/educational information as described below:

Individual or Organization Disclosing Information	Individual or Organization Receiving Information
Disclosing party	Receiving party Lemoore Union High School District
Address	Address 101 East Bush Street
City, State, Zip Code	City, State, Zip Code Lemoore, CA 93245
Telephone: Fax:	Telephone: Fax (559) 924-6600 (559) 924-5086
Disclosing party can also receive information: **Yes** ☐ **No** ☐	**Receiving party can also disclose information:** **Yes** ☐ **No** ☐

Duration: This authorization shall become effective immediately and shall remain in effect until __________or for one year from the date of signature if no date is entered.

Revocation: I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to the releasing agency. Written revocation will be effective upon receipt, but will not apply to information that has already been released in response to this authorization.

Redisclosure: I understand that health information used or disclosed pursuant to the authorization may be subject to redisclosure 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 education Agency is protected as a student record under the Family Education Rights and Privacy Act (FERPA).

Health Info: I understand that authorizing the disclosure of health information is voluntary. I can refuse to sign this authorization. I do not need to sign this form in order to assure medical treatment.

Specify Record(s): Indicate type of information is to be disclosed:
_Medical Information __ Medication Information ___ Psychiatric Information. __Mental Health Information/ Diagnosis(es)
_ Drug/School Information __ STD/HIV Test Results _ Educational Records ___Other:

I request that the information released pursuant to this authorization be used for the following purpose only:

__ Educational Assessment __Educational Planning __ Other: _________________________

A copy of this authorization is as valid as an original. I understand that I have a right to receive a copy of this authorization for my records.

____ Signature of Student's Representative/Adult Student

___________________________ Description of Relationship

__________ Date

____ Witness