CALIFORNIA DEPARTMENT OF EDUCATION
CALIFORNIA SCHOOL FOR THE DEAF, FREMONT

AUTHORIZATION FOR RELEASE OF INFORMATION

Completion of this document authorizes the disclosure of individually identifiable health information and student records in accordance with the Health Insurance Portability and Accountability Act (HIPAA), Family Educational Rights and Privacy Act (FERPA), and Individuals with Disabilities Education Act (IDEA), which pertains to the Privacy and Security of Protected Health Information and Student Records Information.

Instructions to Parents: One form must be completed for each doctor and/or local agency that has provided services. Please include all completed authorization forms with your application.

1. I hereby authorize the following individual or organization:

Individual and/or organization: _____

Address: _____

City: _____ State: _____ Zip Code: _____

2. ❑ To release CONFIDENTIAL information to and/or ❑ receive information from: (check all that apply)

Name of School Representative(s): _____
California School for the Deaf
39350 Gallaudet Drive
Fremont, CA 94538

3. Pertaining to my child:

Student's Name: _____DOB:_____

Address**:** _____

City: _____ State: _____ Zip Code: _____

4. The information to be released relates to: (check all that apply)

(It is understood that the party to whom this information is released will not release it to a third party without appropriate consent.)

☐ Medical	☐ Psychological Services
☐ Educational Services _____	☐ Occupational Therapy/ Physical Therapy
☐ Regional Center/ California Children's Services	☐ Other Professional Services _____
☐ Psychiatric/ Mental Health	☐ Other: Special Education Records

5. The information to be released will only be used for the following purposes: (check all that apply)

• Assessment and Evaluation ❑ •Educational Planning ❑ •Other: _____

Duration: This request shall become effective immediately and shall remain in effect until it is revoked.

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.

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

_____ _____
Signature of Parent, Legal Guardian or Student if 18 years or older Date

To Doctor, Hospital or Clinic: It is essential that the information listed in this authorization be forwarded to the above address as soon as possible. Unfortunately, we cannot pay you for the report we are requesting, as there is no provision with the Dept of Education, State of California, for expenditure of funds for this purpose.