Butte County Special Education Local Plan Area
Authorization for Exchange of Confidential Information

The purpose of this authorization is to allow the gathering and sharing of academic, psychological, and health information to develop an educational plan of comprehensive services for the student below.

Name(s):_____ Birthdate:_____ Social Security #:_____
(Optional)

Parent or Guardian: Name: _____ Phone: _____

Mailing Address: _____

Street Address: _____

Information to be released from: (Initial appropriate agencies/providers.)

____ Butte County Dept. of Employment and Social Services:
_____CSD _____ASD _____Eligibility
____ Butte County Health Department
_____California Children's Services _____CHDP
_____Immunization Clinic Other:_____
____ Butte County Behavioral Health
____ Butte County Office of Education
____ Butte County SELPA
____ Butte County Probation Department
____ Family Services Association
____ Far Northern Regional Center
____ Home Health Care Agency _____
____ Hospital/Medical Centers _____
_____
____ Medical Clinics _____
_____
____ Parent Education Network
____ Physicians/Health Care Providers _____
____ Audiologist_____
____ Ophthalmologist/Optometrist_____
____ School District _____
____ Other (initial each entry) _____
____ Other _____
____ Other _____

Type or description of information requested: (Initial appropriate information.)

____ Educational records, including psycho-educational reports
____ Immunization records
____ Consultation or examination reports
____ Discharge summary
____ Psychological evaluation reports
____ Psychiatric summary including history, diagnosis, treatment, progress
____ Court records
____ Other (initial each entry) _____
____ Other _____

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.

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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 (FERPA).

YOUR RIGHTS: I understand that I have the following rights with respect to this Authorization:

1. I understand that signing this authorization is voluntary.
2. I (the student/child or, if a minor, his or her parent, guardian, parent surrogate or conservator) may receive a copy of this Authorization (Civil Code Section 56.10).
3. 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 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 Equal Rights Protection Act (FERPA) and that the information becomes part of the student's permanent 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.

SIGNATURE AUTHORIZING THIS RELEASE OF INFORMATION:

Date:_____

_____ _____

(Signature of Student) **(Printed name of student)**

_____ _____

(Signature of parent or guardian) **(Printed name of parent or guardian)**

_____ _____

(*Signature of Surrogate Parent) **(Signature of Witness)**

This signature releases only educational information.
Additional information release will require the signature of guardian.

Confidentiality of client maintained according to Education Code Section 49069; California Welfare Institution Code, Section 4514, 42 CFR Part 2.

This information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR Part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is **not** sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

Any information released will meet requirements of HIPPA regarding disclosure and re-disclosure. Recipients are obligated to maintain HIPPA protections for any and all materials released under these conditions.