LAS VIRGENES UNIFIED SCHOOL DISTRICT
AUTHORIZATION FOR RELEASE OF INFORMATION

Student: ____________________________ Parent/Guardian: ______________________________________

DOB: _____________________________ Address: ____

This document authorizes the disclosure and/or use of individually identifiable *health, social, psychological* and *educational* 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. Such information will become part of the person's school record and may be shown to the parent or guardian (or the person, if over 18 years of age) upon demand pursuant to H.R. 69 and E.C. 10751, 10760-61. A photocopy of this is as valid as the original.

Use and disclosure information:
I understand that the purpose is for inclusion in records, which are to be used in planning school programs for this Student. I consent to and authorize the Las Virgenes Unified School District to release such information to the public or private agencies listed below, which are working directly with my child and/or the family. This would include receiving, sending information and conversing with personnel.

The records of my child may be obtained from or sent to:

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Duration:
This authorization shall become effective and shall remain in effect until ________________________________ or for one year from date of signature.

Restrictions:
California law prohibits the School District from making further disclosure of my health information unless the School District obtains another authorization from me or unless such disclosure is specifically required by law.

Parental 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 already acted in accordance with this Authorization.

Re-disclosure:
I understand that the School District will protect this information a prescribed by the Family Equal Rights Protection Act (FERPA) and the information will become part of the student's permanent educational record. The information will be shared with individuals working for or with the School District for the purpose of providing safe, appropriate, and least restrictive educational settings and school health services and programs.

☐ I request a copy of this Authorization ☐ I am not requesting a copy of this Authorization

____ ___________________________

Signature of parent, or student if over age of 18 years Date
Relationship to student

01/2018 revision