Coronado Unified School District
Quality Education for Life

Department of Student Services
201 Sixth Street, Coronado, CA 92118
619.522.8932 www.coronadousd.net

Authorization for Release and Exchange of Information

Student's Full Name _____ Date of Birth _____

Address _____ Telephone Number _____

I authorize the following individuals or organizations to release/exchange information:

Contact Name/Title		**Contact Name/Title**	
Agency/Institution /Department		**Agency/Institution /Department**	Coronado Unified School District
Street Address		**Street Address**	201 Sixth Street
City, State, Zip		**City, State, Zip**	Coronado, CA 92118
Telephone/Fax		**Telephone/Fax**	P: 619.522.8900 x 1032 F: 619.437.4928

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 this 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 educational agency is protected as a student record under the Family Educational Rights and Privacy Act (FERPA), and the recipient may not redisclose the information without parental consent.

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

Specify Record(s) Indicate type of information to be disclosed: ☐ **Educational** ☐ **Mental Health** ☐ **Psychiatric** ☐ **Medical** ☐ **Medication** ☐ **Drug/Alcohol** ☐ **STD/HIV Test Results** ☐ **Other**

Any and all information with regard to the above records may be released, except as specifically listed here:

I request that the information released pursuant to this authorization be used for the following purposes only:
_____Educational Assessment _____Educational Planning _____Coordination of Care

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.

_____ _____ _____
Student or Parent/Legal Guardian *(If student is under 18 years of age)* Relationship to Student Date