



**SANTA CLARA COUNTY OFFICE OF EDUCATION  
AUTHORIZATION FOR EXCHANGE OF  
STUDENT HEALTH AND EDUCATIONAL INFORMATION**

**I GIVE PERMISSION TO:**

\_\_\_\_\_  
*Name of person or organization allowed to release information*

\_\_\_\_\_  
*Address City State Zip*

**TO RELEASE INFORMATION TO AND/OR RECEIVE INFORMATION FROM:**

C/O  
\_\_\_\_\_  
*Name of Student's School Cluster Telephone*

\_\_\_\_\_  
*Address City State Zip Fax*

**PERTAINING TO:**

\_\_\_\_\_  
*Name of Student Medical Record # Date of Birth*

\_\_\_\_\_  
*Address, City State ZIP Telephone*

**DURATION:** This authorization shall become effective immediately and shall remain in effect for one year from the date of signature unless a different date is specified here \_\_\_/\_\_\_/\_\_\_.

**CANCELLATION:** This Authorization is also subject to written cancellation by the parent/guardian/student at any time. The written cancellation will be effective upon receipt. Cancellation will not apply to actions taken based on information obtained from prior authorization(s).

**RE-RELEASE:** I understand that the recipient may *not* lawfully further use or release the information unless another authorization is obtained from me or unless such use or release is specifically required or permitted by law.

**CONDITIONS:** I understand that eligibility for *educational services* may be based on my giving or refusing to give this authorization. *Federal Register Section 164.508(c)(2)(ii)*

**SPECIFIC RECORDS:** *Check the box and initial which type of information is to be released.*

- |  |   |
|--|---|
| Initial _____ <input type="checkbox"/> Immunizations       | Initial _____ <input type="checkbox"/> Health & Developmental |
| Initial _____ <input type="checkbox"/> Educational         | Initial _____ <input type="checkbox"/> Hearing/Audiological   |
| Initial _____ <input type="checkbox"/> Speech & Language   | Initial _____ <input type="checkbox"/> Birth Records          |
| Initial _____ <input type="checkbox"/> Medical Information | _____ <input type="checkbox"/> Mother's Maiden Name           |
| Initial _____ <input type="checkbox"/> Vision              | Initial _____ <input type="checkbox"/> Other (Specify: _____) |

*The person or organization who receives the health and/or educational information authorized on this form, may only use it for the following educational purposes:*

- Eligibility    Planning    Health Services    Other (Specify: \_\_\_\_\_)

*Parent/Guardian or Student will receive a copy of this authorization.*

Date: \_\_\_/\_\_\_/\_\_\_   Signature: \_\_\_\_\_

*If signed by other than student, indicate relationship:*    Mother    Father    Guardian

Fax of recipient

In Care Of