Temecula Valley Unified School District

AUTHORIZATION FOR USE AND /OR DISCLOSURE FOR INFORMATION

Name of student (list other names used)	*Medical Record Number (if applicable)*	*Date of Birth*
Address of student	*Phone No.*	*Other Phone No.*

I authorize the following individual or organization to disclose the above named individual's medical/educational information as described below:

Individual or Organization Disclosing Information:	**Individual or Organization Receiving Information:**
	Dr. Xochitl Leevers [Mindwell Gardens]
Disclosing Party	*Receiving party*
	44025 Margarita Rd., Suite 101
Address	*Address*
	Temecula, CA, 92592
City, State, Zip Code	*City, State, Zip Code*
	dr.leevers@mindwellgardens.com
Telephone: ___________________ *Fax:* ______________	*Telephone:* (951) 331-3938 Ext. 3
	Fax: (951) 331-3843

Duration: This authorization shall become effective immediately and shall remain in effect until __________ (date) 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)

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 is to be disclosed:

☐ **Medical** ☐ **Medication** ☐ **Psychiatric** ☐ **Mental Health** ☐ **Vision**

☐ **Drug/Alcohol** ☐ **STD/HIV Test Results** ☐ **Educational** ☐ **Audiological** **Other:** __________

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

I request that the information release pursuant to this authorization be used for the following purposes only:

Educational Assessment   Educational Planning   Other: ____________________________

A copy of this authorization is as valid as an original.

I understand that I have the right to receive a copy of this authorization for my records.

Signature of Student or Student's Representative	*Description of Relationship to Student*	*Date*