

Student Support Services Authorization for Use and/or Disclosure of Information

The use and distribution of this form is limited to employees of public school agencies within the San Luis Obispo County Special Education Local Plan Area (SELPA).

Student Name (First, MI, Last):				DOB:
Student Address		Medical Record # (if applicable)	Phone Number	Alternate Phone
	owing individual or educational informa		disclose the nam	ed individual's
Individual or Organization Street Address			Receiving Party San Luis Coastal Unified School District Individual or Organization 1500 Lizzie Street, G1 Street Address	
		<u>s</u>		
		_		
City, State, Zip Code		_	San Luis Obispo, CA 93401 City, State, Zip Code	
Telephone	Fax		(805) 549-1220 Telephone	(805) 543-6567 Fax
Yes, Information may Duration:Revocation:Redisclosure:	be mutually and freely exchanged between Disclosing and Receiving Parties (initial) 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. I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to the Disclosing Party. Written revocation will be effective upon receipt but will not apply to information that has already been released in response to this authorization. I understand that medical/educational information used or disclosed pursuant to this			
Health Information:	authorization may be subject to redisclosure by the recipient and it will no longer be protected by federal laws and 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). I understand that authorizing the disclosure of health information is voluntary. I can refuse to sign this authorization. I do not need to sigh this form in order to assure medical			
Specify Record(s):	treatment. □ Medical □ Mental Health	□ Medication□ Educational	□ Psychiate	
Any and all information	with regard to the above r			
	eration of education servic rsuant to this authorization Other.			
	tion is as valid as an origir ords. I understand that I m			ve a copy of this ne information to be used on
Signature of Student or	Student's Representative	 Description	on of Relationship to S	tudent Date