Student Services Department
181 Encinal Avenue, Atherton, CA 94027
(650) 321-7140 Fax: (650) 292-2200

RELEASE OF HEALTH INFORMATION

This authorization allows information relevant to your child's health and education to go to, from and between the representatives of the Menlo Park City School District and representatives of the agencies and/or person(s) listed below. This information will be used in assessing your child's educational needs and in developing appropriate educational programs and health care plans. Both pages must be completed and submitted.

Date ________________ Check Site: ☐Heritage Oak ☐Laurel ☐Encinal ☐Oak Knoll ☐Hillview

Student Name____ DOB _____________________

Home Address____

Agency or Person: ______________________________________

Address: ______________________________________

Phone: ____________________ **Fax:** ____________________

Contact: ______________________________________

Agency or Person: ______________________________________

Address: ______________________________________

Phone: ____________________ **Fax:** ____________________

Contact: ______________________________________

Agency or Person: ______________________________________

Address: ______________________________________

Phone: ____________________ **Fax:** ____________________

Contact: ______________________________________

Agency or Person: MPCSD Student Services Department / School Nurse

Address: 181 Encinal Avenue, Atherton CA 94027

Phone: 650-321-7140 Fax: 650-292-2200

Check and initial all that apply:

☐ _____ History & Physical ☐ _____ Consultation Report ☐ _____ Lab / X-Ray Report ☐ _____ Immunization Record

☐ _____ Clinic Summary ☐ _____ Progress Notes ☐ _____ Physician's Orders ☐ _____ Operative Report

☐ _____ Mental Health Records ☐ _____ Other: ____

Student Name____ DOB ____________________

Authorization Restrictions and Rights

1. Signing this Authorization is voluntary. You can refuse to sign this Authorization. Refusing to sign this Authorization will not affect the District's commitment to provide a quality education for your child. However, without the proper health information, the District may not be able to properly plan and provide educational services for your child.

2. This Authorization may be revoked in part or in whole at any time.
   a. To revoke this Authorization with respect to the District, you must provide the District with a written request to revoke this Authorization. The revocation will take effect when the District receives your written request.
   b. To revoke this Authorization with respect to the organization or individual listed in Section B, you must provide the organization or individual listed in Section B with a written request to revoke this Authorization. The revocation will take effect when the organization or individual listed in Section B receives your written request. Please provide the District with a copy of your request for revocation.
   c. Any information disclosed before your written request for revocation is received by the District or the organization or individual listed in Section B may be used as permitted in this Authorization.

3. You have a right to receive a signed copy of this Authorization. Upon request, you will be provided a copy of this Authorization.

4. The District and many other organizations and individuals such as physicians, hospitals and health plans are required by law to keep your child's health information confidential. If you authorize the disclosure of your child's health information to a person or entity that is not legally required to keep it confidential, the information may be re-disclosed and may no longer be protected by state or federal law. Unless otherwise provided in this Authorization or permitted or required by law, no further disclosure of your child's health information will be made by the District without your express authorization.

5. A photocopy or fax copy of this Authorization is as valid as the original.

By signing below, I authorize the disclosure and use of the health information specified above, and further acknowledge that I have read and understand the Authorization Restrictions and Rights. Unless otherwise revoked, this Authorization is effective upon my signing it and shall expire on ________________ (insert applicable date or event). If no date is indicated, this shall expire 12 months after the date of signing this authorization.

Parent/Guardian Signature	Print Name	Relationship to Student	Date