West Contra Costa Unified School District
Pupil Services Center
2465 Dolan Way, San Pablo, CA 94806
Telephone: 510-741-2801 Fax: 510-724-8829

AUTHORIZATION FOR RELEASE OF INFORMATION

A. Student/Patient Information

Name: ______________________ Date of Birth: ______________
Home Address: ______________________________
Telephone Number: ______________ Medical Record Number (if applicable): ______________
Previous School: ______________ Present School: _Transition Program____________

B. Educational/Health Information to be Released From

Agency/Person: ______________________________
Address: ______________________________
Telephone Number: ______________ Fax Number: ______________

C. Educational/Health Information to be Released to and Used By:

Agency/Individual: __Contra Costa College ______________________
Address: ______2600 Mission Bell Drive, San Pablo, CA 94806 ______________
Telephone Number: __510-235-7800 x7220_________ Fax Number: ___510-234-1544________________

I authorize the District to further release the educational/health information to the following agencies or persons for the purposes stated below (attach additional pages if more space needed):

Agency/Individual: ___RCEB______________________________
Address: ______________________________
Telephone Number: ______________ Fax Number: ______________

Agency/Individual: ______________________________
Address: ______________________________
Telephone Number: ______________ Fax Number: ______________

D. Purpose of the Requested Educational/Health Information

- ☐ Release of educational/health information at the request of student's parent, guardian or legal representative.
- ☑ Provide and plan educational services for student.
- ☐ Other: ______________________________

E. Type/Description of Educational/Health Information to be Released

☐ History and Physical Exams	☐ Treatment Information	☐ Psychological Records
☐ Current Medical Information	☐ Mental Health Records	☑ IEP/SST Data
☐ Immunization Record	☐ Admission and Discharge Summaries	

☐ Other/Comments: ______________________________
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F. Expiration of Authorization

Unless otherwise revoked, this Authorization is effective upon my signing and shall expire __________________________ (insert date or event). If no date is indicated, this Authorization will expire twelve (12) months after the date of signing this Authorization.

G. Signature

By signing below, I authorize the disclosure and use of the educational/health information specified above, and further acknowledge that I have read and understand the Authorization Restrictions and Rights.

Parent/Guardian Signature: ___________________________________ Date: ______________
(Adult Student)

Print Name: _____________________________ Relationship to Student: ____________________

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 educational/health information, the District may not be able to properly plan and provide educational services for your child.

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

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 educational/health information confidential. If you authorize the disclosure of your child's educational/health information to a person or entity that is not legally required to keep it confidential, the information may be re-disclosed an my no longer be protected by state or federal law.

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