❑ ADELANTO
❑ APPLE VALLEY
❑ BAKER VALLEY
❑ BARSTOW
❑ BEAR VALLEY
❑ HELENDALE
❑ HESPERIA
❑ LUCERNE VALLEY
❑ NEEDLES
❑ ORO GRANDE
❑ SBCSS - D/M OPERATIONS
❑ SILVER VALLEY
❑ SNOWLINE
❑ TRONA
❑ VICTOR ELEM
❑ VVUHSD
❑ CHARTER SCHOOL _____

DESERT/MOUNTAIN SPECIAL EDUCATION LOCAL PLAN AREA
17800 HIGHWAY 18 - APPLE VALLEY, CA 92307 - (760) 242-6333

AUTHORIZATION FOR USE AND/OR DISCLOSURE OF INFORMATION

Name of Student (list other names used)	Medical Record No. (if applicable)	Date of Birth
Address of Student	Home Telephone No.	Other Contact No.

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

Individual or Organization Receiving Information:	**Individual or Organization Disclosing Information:**
Receiving Party	Disclosing Party
Address	Address
City, State, Zip Code	City, State, Zip Code
Telephone No. _____ Fax No. _____	Telephone No. _____ Fax No. _____

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 educational and 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 Information: I understand that authorizing the disclosure of health information is voluntary. I can refuse to sign this authorization. I do not need to sign this form in order to assure medical treatment.

Specify Record(s): Indicate type of information to be disclosed.

☐ Medical/Medication
☐ Mental Health/Psychiatric
☐ Educational Records
☐ Drug/Alcohol
☐ STD/HIV Test Results
☐ Other: _____

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

☐ Educational Assessment ☐ Educational Planning ☐ Other: _____

A copy of this authorization is as valid as an original.
I understand that I have a right to receive a copy of this authorization for my records.

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

D/M 63 (Rev. 2/04)