Contra Costa County Office of Education

77 Santa Barbara Road, Pleasant Hill. CA 94523 • (925) 942-3388
Lynn Mackey, Superintendent of Schools

RELEASE AND EXCHANGE OF INFORMATION AUTHORIZATION

THIS FORM MUST BE COMPLETELY FILLED OUT BEFORE REQUESTING PARENT SIGNATURE
Do not leave areas blank. Mark N/A where appropriate.

Name of Student (Including Other Names Used) _____ Current School of Attendance _____ Date of Birth _____

Student Home Address _____ Home Phone Number _____ Other Phone Number _____

I authorize each of the following organizations to release and exchange with one another the above-named individual's educational, medical, mental health, probation, court and education records and information for the coordination of services and actions taken by these agencies in serving the above-named individual, including, but not limited to, educational planning, mental health planning and medical planning.

(Agency/Person name)

_____
(Address)

_____
(City, State) (Zip)

_____
(Phone/Contact)

Contra Costa County Office of Education
(Including SDC, Court and Community Schools)
77 Santa Barbara Road
Pleasant Hill, CA 94523
Phone: 925-942-3388
Fax: 925-942-3353

Duration: I understand that my consent to this authorization shall become effective immediately and shall remain in effect until _____ (insert date or event) or for one year from the date of signature if no date or event is entered**.**

Voluntary: I understand that signing this authorization is voluntary. I can refuse to sign this authorization. Refusing to sign will not affect the agencies' obligations to serve the above-named individual but may affect their ability to properly plan and provide services to the above-named individual.

Revocation: I understand that I have the right to revoke this authorization, in writing, at any time. To revoke this authorization, I must provide the organizations listed above with a written request to revoke this authorization. The revocation will take place when the organizations listed receive my revocation. Any information disclosed before my revocation is received by the organizations listed above may be used as provided for in this authorization.

Copy: I understand that a copy (e.g. photocopy, facsimile, electronic copy) of this authorization is valid as an original. I understand that I have the right to receive a signed copy of this authorization within no more than five (5) business days of my request for a copy.

Redisclosure: I understand that the medical and health information used or disclosed pursuant to this authorization may be subject to disclosure by the recipient and is no longer protected by federal laws and regulations regarding the privacy of protected health information, including, but not limited to, the Health Insurance Portability and Accountability Act ("HIPAA"). I further understand that the confidentiality of information released to a public educational agency is protected only as a student record under the Family Educational Rights and Privacy Act ("FERPA") and related California law—student records which I am hereby authorizing the release and exchange of between the above-named agencies..

Health Info: I understand that this is an authorization for the **full disclosure** of health and medical information. I understand that authorizing the release and exchange of health information is voluntary. I can refuse to sign this authorization. I do not need to sign this form in order to ensure medical treatment.

Date _____ Signature of Parent or Legal Guardian _____ Relationship to Above-Named Individual _____

Nothing in this Release and Exchange of Information Authorization is intended to limit access to the above-named individual's juvenile case file as allowed by California Welfare and Institutions Code section 827 and/or the exchange and release of information otherwise allowed under state and federal law.