Release Of Information

Springs Charter Schools
43438 Business Park Drive
Temecula, CA 92590
Phone: 951-252-8882

Student Name: ____DOB: ______________ Grade: __________

School Site: ____

Student's Address: ____

City: ____________________________ State: __________________________ Zip: _______________

Primary Phone: __________________ Primary Email: ____

Individual or Organization Receiving Information	Individual or Organization Disclosing Information
Student Services Department Email: School.nurse@springscs.org Telephone: 951-234-3776 Fax: 951-489-0494	_______________________________________ Name of Physician or Medical Organization _______________________________________ Telephone # Fax #

Duration: This authorization shall become effective and shall remain in effect until _______________ (date) or for one year from the date of signature if no date is entered.

Revocation: I have the right to revoke this authorization at any time by sending 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 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 that 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 Info: I understand that authorizing the disclosure of health information is voluntary. I can refuse to sign this authorization, and I do not need to sign this form in order to assure medical treatment.

Specify Record(s) to be disclosed: ▢ Medical ▢ Medication ▢ Vision/Hearing ▢ Audiological ▢ Mental Health ▢ Education

I request that the information released pursuant to this authorization be used for the following purposes only:
▢ Health Assessment ▢ Mental health assessment Other____

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

I understand and agree that information received by Springs Charter School may be scanned and emailed to necessary personnel.

____________________________________ ______________________________ _____________
Signature of Parent/Legal Guardian/Surrogate Description of Relationship to Student Date

____ _____________
Signature of Student (if over 12 years of age and request is for mental health records) Date

Return Fax: 951-489-0494 / Email: school.nurse@springscs.org