POMONA UNIFIED SCHOOL DISTRICT

Authorization for Release of Medical Records

Please Request Medical Information FROM:

_____
Name of Health Care Provider

_____
Name of Medical Office or Hospital

_____
Street Address

_____
City, State, Zip Code

Phone: _____

Fax: _____

Please SEND Medical Information TO:

School Site: _____

School Nurse: _____

Address: _____

Pomona, CA _____

Phone: (909) 397-_____

Fax: (909) _____

I hereby authorize _____ to release and/or disclose (by the following means: ____ Phone ____ Fax ____ U.S. Mail) the medical information pertaining to my child as indicated below to Pomona Unified School District Attention: Health Office and School Nurse listed above.

Please release and or disclose records and information regarding:

_____	_____	_____
Name of Patient	Date of Birth	Medical Record Number (or SSN)
_____	_____	( )_____
Address	City State Zip Code	Telephone Number

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

Revocation: This authorization may be revoked in writing by the undersigned at any time prior to the release of information from the disclosing party. Written revocation will not affect any action taken in reliance on this authorization before the written revocation was received

Re-disclosure: I understand that the requestor may not lawfully further use or disclose the health information unless another authorization is obtained from me or unless disclosure is specifically required or permitted by law.

Specify records to be Released and/or Disclosed:

_____

_____

_____

I request that the health information released and/or disclosed pursuant to this authorization be used for the following purpose: The information will become part of student's education record and will move with the student _____ (parent initials)

A copy of this authorization is valid as an original. I have a right to receive a copy of this authorization. The copy is for me to keep.

_____	_____	_____
Date	Signature of Parent or Guardian	Relationship to Patient