Print Form

GLENDORA UNIFIED SCHOOL DISTRICT

Authorization for Release of Information

This information is for confidential use of the school personnel who are directly concerned with helping this student – or for the doctor or agency concerned.

Student's Name: _____ DOB: _____

Parent's Name: _____

Home Address: _____

Number Street City Zip Code

I hereby authorize ☐ Glendora Unified School District

☐ Doctor or Agency: _____

Address: _____

_____

Phone: ( ) _____

to release _____ as a result of examination made on the above

mentioned pupil, only for the purpose of _____

(State use of information)

Requested by ☐ Glendora U.S.D., 500 N. Loraine Ave., Glendora, CA 91741

☐ Doctor or Agency: _____

Address: _____

_____

Phone: ( ) _____

Release obtained by: _____ _____

(Name of person) (Title)

This authorization shall become effective immediately and shall remain in effect until _____ or no longer needed.

(Date)

I understand that requestor may not further use or disclose the medical information unless another authorization is obtained from me or unless such use or disclosure is specifically required or permitted by law.

I further understand that I have a right to receive a copy of this authorization upon my request.

Copy requested and received: ☐ Yes ☐ No Initial: _____

_____ _____ _____

Signature of Parent/Guardian Relationship to Student Date