Stanislaus County Office of Education
Tom Changnon, Superintendent

Child & Family Services

Tony Jordan, Executive Director
1100 H Street • Modesto CA 95354 • (209) 238-1800 • FAX (209) 238-4217

Parent /Guardian Consent for Release of Information

Name of Child: _____
(Last) *(First)* *(Initial)*

Date: _____ DOB: _____

Please send the requested information to:
Attn: _____
Title: _____
Address: _____
Phone: _____ Fax: _____

I authorize the following individual or organization to disclose the above named individual's medical/educational information as described below and this information is to be released from:
(check as needed)

___ _____ School District
___ California Children's Services (CCS)
___ CCS Medical Therapy Unit
___ Valley Mtn. Regional Center/Regional Center
___ Stanislaus County Health Services Agency
___ Stanislaus County Office of Education
___ Golden Valley Health Centers
___ Doctor's Medical Center
___ Emanuel Hospital
___ Memorial Hospital
___ DMC Foundation
___ Physician / Clinic / Other _____
___ Physician / Clinic / Other _____
___ Physician / Clinic/ Other _____

___ Head Start
___ Valley Oak Hospital
___ Shriner's Hospital
___ Oakland Children's Hospital
___ Fresno Diagnostic Clinic
___ University Medical Center
___ Lucille Packard Children's
___ Gould Medical Group
___ Kaiser Permanente Medical Group
___ Infant Referral Program/Early Start
___ Children's Hospital – Central CA
___ Sutter Gould
___ Leaps and Bounds
___ Sierra Vista
___ Child Family Services

Description of information to be disclosed (check as needed):

___ Medical Records
___ Medication Information
___ Physician Orders
___ Immunization Records
___ Educational Records (Speech / Language)
___ Mental Health Information
___ Vision
___ Lab Results/X-Ray Reports
___ Dental
___ Other: _____

White: Child's File Yellow: Agency Pink: Parent

Mandatory
Revised 1/14
CF/R-34

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Parent /Guardian Consent for Release of Information

Name of Child: _____
(Last) (First) (Initial)

Date: _____ DOB: _____

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

___ Educational Assessment ___ Other: _____
___ Educational Plan ___ Other: _____
___ Health Care Plan ___ Other: _____

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 Head Start agency listed on this form. Written revocation will be effective upon receipt, but will not apply to information that has already been disclosed in response to this authorization.

Redisclosure: I understand that protected health information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and it may no longer be protected by federal laws and regulations regarding the privacy of protected health information.

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.

_____ _____
Parent/Guardian Date

_____ _____
Print Name Document Interpreted to Parent by (Staff Name)

A copy of this authorization is as valid as the original. I understand that I am entitled to receive a copy of this authorization.

White: Child's File Yellow: Agency Pink: Parent

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