SANTA MONICA – MALIBU UNIFIED SCHOOL DISTRICT
1651 Sixteenth Street, Santa Monica, California, 90404-3891 – (310) 450-8338
Department of Health Services

AUTHORIZATION FOR USE OR DISCLOSURE OF MEDICAL INFORMATION

EXPLANATION – This authorization for use or disclosure of medical information is being requested of you to comply with the terms of the *Confidentiality of Medical Information act of 1981,Section 56, et. seq., California Civil Code.*

I hereby authorize Physician's Name: _____ Phone Number: _____

Hospital or Health Care **provider**: _____

Address: _____

to furnish School Name: _____

Address: _____

Attn: School Nurse _____

medical records and information pertaining to medical history, mental or physical condition, services rendered, or treatment of your patient:

Student's Name: _____ Date of Birth: _____

This authorization is limited to the following medical records and type of information:

☐ Summary of significant medical records, including health history, neurological , physical, or emotional findings, and any recommendations for school programs.

☐ Other: _____

The requestor may only use the medical records to help plan the best educational program to meet the student's needs.

This authorization shall become effective immediately and shall remain in effect until _____ (date).

I understand the 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.

Copy requested and received: ☐ Yes ☐ No Initials _____

Signature:

Signed: _____ Date: _____
(patient/parent/legal guardian)

Witness: _____ Date: _____