RELEASE OF INFORMATION

Springs CHARTER SCHOOLS
EMPIRE SPRINGS HARBOR SPRINGS RIVER SPRINGS CITRUS SPRINGS

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

Student: _____ School:_____ DOB: _____

Student Address: _____ _____

City:_____ Zip Code: _____ Grade: _____

Primary Phone: _____ Parent Email: _____

Individual or Organization Receiving Information

Kelly Ouellette RN, M.Ed Pupil Services
River Springs Charter School
Empire Springs Charter School
Harbor Springs Charter School
Citrus Springs Charter School

Receiving Party:

pupil.services@springscs.org

951-225-8833 951-676-9055

Telephone # **Fax #**

Individual or Organization Disclosing Information

_____

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 understand that I have the right to revoke this authorization, in writing, at any time by sending such 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 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): Indicate type of information to be disclosed:

⌗ Medical ⌗ Medication ⌗ Vision/Hearing ⌗ Audiological

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

⌗ 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 e-mailed to necessary personnel.

_____ _____ _____

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