FLAGSTAFF UNIFIED School District

Student Support Services
(928) 527-6140
Flagstaff Unified School District, 3285 East Sparrow Avenue, Flagstaff, AZ 86004

Authorization for Release of Confidential Information

Section 1

I authorize the use or disclosure of the specific confidential information about my child as described below.

_____ _____ _____
Students/Child's Name | Date of Birth | School

Organization/Persons authorized to disclose information to Flagstaff Unified School District (FUSD):

_____
Name/Organization/Medical Provider

_____
Address

_____ _____ _____
City | State | Zip

_____ _____
Phone | Fax

_____
Email Address

Dates of records from _____ to _____

FUSD Department/Persons authorized to:

☐ Receive protected information from outside agency/person
☐ Release protected information to outside agency/person

_____
FUSD Department or School

_____
Address

_____ _____ _____
City | State | Zip

_____ _____
Phone | Fax

_____
FUSD Contact Person/Job Title

_____ _____
Email Address | Signature

Section 2

I understand this information will be used to assist school personnel with making decisions about the following:

☐ Determining eligibility for special education or 504 plan
☐ Determining the student's current levels of functioning or educational needs
☐ Other (specify): _____
_____
_____

Section 3

By marking the boxes below, I authorize the use/disclosure of the following health or education records:

☐ Physician's diagnostic statement
☐ Medical information (e.g. hearing or vision report, health assessment statement, history and physical exam)
☐ Speech-language, occupational therapy, & physical therapy reports
☐ Progress notes
☐ Psychiatric/psychological evaluation reports and testing
☐ Treatment plan, discharge statement, and/or Crisis Plan
☐ Education records (transcript, discipline, attendance)
☐ Special education records (evaluation reports, IEP, behavior plan)
☐ Other (specify):_____

Section 4

I understand that

- This authorization is voluntary and I may refuse to sign it without affecting the services my child receives from any persons or agencies outside of school.
- The information to be disclosed or used can be communicated via fax, mail, email, or phone conversation.
- I can revoke this authorization at any time by sending a written note to the FUSD employee who requested the information (listed in section 1). I understand that the request to withdraw my consent will be valid as soon as the person receives my note, but it will not apply to information that was already shared before I withdrew my consent.
- Use of this information for any reasons other than the expressed reasons stated in Section 2 is prohibited.
- I may inspect or obtain a copy of the information to be used or disclosed.
- FUSD will maintain the privacy of student records pursuant to the provisions of the Family Educational rights and Privacy Act. However, I understand that the information used or disclosed under the authorization may be subject to unauthorized re-disclosure by the person(s) receiving it, and may then no longer be protected.
- I have a right to obtain a copy of this consent from if I ask for one, and the copy of the form is as good as the original.

Section 5

I consent to the use/disclosure of the above information.

_____ _____ _____
Signature of Parent/Legal Guardian/Eligible Student | Relationship | Date

This authorization expires on _____ (not to exceed one year from date of signature).

Revised 1/19/16