NORRIS SCHOOL DISTRICT
6940 Calloway Drive • Bakersfield, CA 93312 • p 661.387.7000 • f 661.399.9750

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

To _____ Date:_____
(Name of person or Physician, Agency, which has information)
Physician/Agency Fax : _(____)_____Phone: __(____)_____

REGARDING:

Student Name:_____ Birth Date:_____Gender: _____

Parent / Guardian Names: _____

This information is to be released to:_____ Fax: 661-399-9750

If there are any questions, or more information is needed, please call:

Name: _____ Phone:(661) 387-7000

- ☐ The following information is being requested by the Norris School District to assist in the educational planning for the student identified above. These records will become part of the school / educational records maintained by the school district as confidential files. This request remains in effect until records are received. _____ Parent initials
- ☐ The information will be shared with _____ for joint program planning and will become part of the agency records for this student _____ Parent initials
- ☐ The request will remain in effect during the current school year and will allow the exchange of information between _____and _____ to facilitate the educational planning for this student.
- ☐ It will no longer be effective after _____. _____ Parent initials

Information Requested:

☐ Educational ☐ Psychological ☐ Health/ Medical ☐ Treatment Plan

☐ Diagnosis ☐ Other_____

Parent/Guardian Signature: _____

Date: _____