WEST END SPECIAL EDUCATION LOCAL PLAN AREA
AUTHORIZATION FOR USE AND/OR DISCLOSURE OF INFORMATION

Name of Student (list other names used) *Date of Birth* *District of Residence*

Address of Student *Phone Number* *Email Address*

I authorize the following individual or organization to exchange the above-named individual's educational information as described below:

Individual or Organization	**Individual or Organization**
Sharon Neault, Ombudsman 8265 Aspen Ave. Ste. 200 Rancho Cucamonga, CA 91730 Phone: (909) 476 - 6117 Fax: (909) 466 - 4230	*Individual or Organization* *Address* *City, State, Zip Code* *Phone:* *Fax:*

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 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 re-disclosure 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.

Specify Record(s): Indicate the type of information to be disclosed:

☐ Educational ☐ Other

Any and all information with regard to the above records may be release except as specifically provided here:

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

☐ Educational Planning ☐ Other

A copy of this authorization is as valid as an original.

I understand that I have the right to receive a copy of this authorization for my records.

_____ _____ _____

Signature of Student or Students Representative *Description of Relationship to Student* *Date*