Patient Name

UCI Health

Plain Language-Authorization for Disclosure of Educational Information

School Information

(*Plain Language Authorization to Disclose Educational Information)*

My Information

My Name: _____ My Date of Birth: _____

My Address: _____

City: _____State: _____Zip Code: _____

My School

My school is: _____

School Address: _____

City: _____State: _____ Zip Code: _____

My school's phone number is: (_____)_____

I have an *Individualized Educational Program* (**IEP**) and I want someone to help me make choices about school.

The person I want to help me is:_____

This person's phone number is: (_____)_____-_____

Check the ways you want this person to help you

☐ I want this person to come to my *Individualized Educational Program* (**IEP**) meetings.

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School Information

☐ I want this person to have access to all of my school information and records.

☐ I only want this person to have the following information of mine:

_____

_____

This person can see my records until this date:_____, or for 5 years, unless I sign a form that says this person can no longer see my records.

My Signature:

My signature:_____

The date today is: _____/_____/_____