



PURPOSE: As a parent, guardian or student, you have the right to give permission for the release of your child's records with other persons or agencies. This request provides you with the opportunity to approve or not approve such a request unless release of records is allowed under the Family Education Rights and Privacy Act, FERPA, or its implementing regulations (for example, transfer of records from one school district to another)

AUTHORIZATION FOR RELEASE/EXCHANGE PSYCHOLOGICAL AND MEDICAL RECORDS

Student Name: _____ Date: _____

Student Birthdate: _____ Parent(s): _____

I hereby authorize the release of records:

From: _____ To: _____
(Name of agency/school/person) (Name of agency/school/person)

(Street Address) (Address)

(City, State, Zip) (City, State, Zip)

Phone: _____ Phone: _____

Person making request: _____

Describe the records to be disclosed:

- Health Records Psychological and Counseling Records Special Education Records
- Transcripts Communication/exchange of information between and agency and school
- Educational Records Other Specify: _____

Release Requiring Specific Consent: Specific consent is required for release of the following information. Minor signature is also required at the ages specified below. Medical records are regulated by RCW 70.02. Mental health services for minors are regulated under RCW Chapter 71.34; Drug and alcohol abuse and treatment records are protected under 42 C.F.R § 2; Information related to HIV/AIDS or sexually transmitted disease diagnosis and treatment of minors is provided under RCW 70.24.110.

I specifically authorized the release of records relating to:

- Reproductive Care Mental Health/Illness (age 13 and older) Drug/Alcohol Abuse (age 13 and older) Sexually Transmitted Diseases or HIV/AIDS (age 14 and older)

The reason for disclosing the record(s) is:

- An Evaluation or Reevaluation Process A program review An IEP is being developed
- Support Therapeutic Goals Other Specify: _____

I understand and acknowledge the following:

- Released information will be treated in a confidential manner by the school district under the provisions of the Family Education Rights and Privacy Act (FERPA). FERPA prohibits disclosure of personally identifiable information without consent except in limited circumstances. If the request is for health or medical information, the medical information received by the district is protected under FERPA privacy standards by a school district and not the Health Insurance Portability and Accountability Act (HIPAA).
- The information released in response to this authorization may be re-disclosed to other parties.
- My consent for the release of records is voluntary and I can withdraw my consent at any time, except to the extent that information has already been released in reliance upon this authorization. Revocation must be in writing.

This authorization is valid from _____ to _____

Parent/Guardian Signature

Date

Student Signature

Date