

**Issaquah Public Schools**

5150 220<sup>th</sup> Ave SE

Issaquah, WA 98029

425-837-7090

**Authorization for Release of Medical Records and/or Exchange of Information**

**PURPOSE:** As a parent, guardian or student, you have the right to give permission or not 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 one of the exceptions under the rules implementing the Family Education Rights and Privacy Act, FERPA, (for example, transfer of records from one school district to another).

Student Name: \_\_\_\_\_

Date: \_\_\_\_\_

Student DOB: \_\_\_\_\_

Parents/Guardian: \_\_\_\_\_

**I hereby authorize the release of records:**

From: \_\_\_\_\_  
*(Name of agency/person)*

To: \_\_\_\_\_  
*(Person/Agency Making the Request)*

\_\_\_\_\_  
*Street Address*

\_\_\_\_\_  
*Street Address*

\_\_\_\_\_  
*City, State, Zip*

\_\_\_\_\_  
*City, State, Zip*

\_\_\_\_\_  
*Phone*

\_\_\_\_\_  
*Phone*

\_\_\_\_\_  
*Fax*

\_\_\_\_\_  
*Fax*

**Describe the records to be disclosed:**

Health Records

Transcripts

Psychological and Counseling Records

Communication/Exchange of information between agency and school

Special Education Records

Other (specify): \_\_\_\_\_

**Release Requiring Specific Consent:** Specific consent is required for release of the following information. Student consent is also required at the ages specified in parentheses below. Mental health records are protected under RCW 71.05.390 and Chapter 21.34 RCW. Drug and alcohol abuse and treatment records are protected under 42 C.F.R. §2; Information related to HIV/AIDS or sexually transmitted diseases is protected under RCW 70.24.105.

***I specifically authorize the release of records relating to:***

Reproductive care (student consent always required)

Mental Health/Illness (age 13 and older)

Sexually Transmitted Diseases or HIV/AIDS (age 14 and older)

Drug/Alcohol Abuse (age 13 and older)

**The reason for disclosing the record(s) is:**

An Evaluation or Reevaluation Process

An IEP is Being Developed

A Program Review

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.
- I do not need to sign this form to assure treatment or payment. My treatment, payment, enrollment in any health plan, or eligibility for benefits is not conditioned on signing this authorization form.
- My consent for the release of records is voluntary and I can withdraw 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 \_\_\_\_/\_\_\_\_/\_\_\_\_.

Note: If no date is specified above, authorization will expire one year from the date of the signature below.

\_\_\_\_\_  
Parent/Guardian Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Student Signature

\_\_\_\_\_  
Date