Kent School District
12033 S.E. 256th Street • Kent, WA 98030-6643

AUTHORIZATION FOR EXCHANGE OF CONFIDENTIAL MEDICAL INFORMATION

RE:______________________________ Birthdate:__________ Grade:________
(Student's Name)

School:______________________________ Phone:______________________ Date:______________

I hereby authorize the exchange of confidential medical records regarding the above named student for the purpose of establishing special education and/or 504 eligibility, placement, program planning and/or coordination of health services between

(School Name) ______ Street Address ______ State ______ Zip ______

and

Name of agency/physician/counselor/, etc. ______ Phone Number ______ Fax Number ______

Street Address ______ City ______ State ______ Zip ______

Staff names who have permission to access this information must be specified:

School Nurse:______________________ My child's teacher:______________________

School Psychologist:______________________ Counselor:______________________

Administrator:______________________ Others: (specify)______________________

Others: (specify)______________________

Date of Service for records release: From ______________________ to ______________________

☐ Outpatient Clinic Notes	☐ Occupational Therapy Reports	☐ Physical Therapy Reports
☐ Discharge Summary	☐ Speech Language Reports	☐ Other______________
☐ Other______________	☐ Other ______________	☐ Other ______________

Purpose of Release:

☐ Continuing Care	☐ Coordination with school	☐ Legal
☐ Other ______________	☐ Other ______________	☐ Other ______________

To those receiving information under this authorization: This information disclosed to you is protected by state and federal law. You are prohibited from releasing it to any agency or person not listed on this form without specific written consent of the person to whom it pertains. A general authorization for release of information is not sufficient. See Chapter 70.02.005-904 RCW. *Envelope should be marked "**CONFIDENTIAL.**"*

By signing this medical records or information disclosure authorization, I understand that the provider of such records or information cannot guarantee or assure that such records or information will not be further released or re-disclosed to third parties by the recipient. I also understand that the provider cannot guarantee that such records or information remain protected by federal or state law. I understand that when such records or information are provided to a school district where my student is enrolled, further disclosure of such records or information no longer protected by the Health Insurance Portability and Accountability Act (HIPAA), may nevertheless be regulated under other federal law (such as the Family Educational Rights and Privacy Act of 1974 (FERPA)) or corresponding state law. This medical authorization is valid for one year and may be revoked in writing to the school. I understand that once the information has been released according to the terms of this authorization, the information cannot be recalled.

PLEASE RETURN TO:

____
Signature of parent, guardian, or adult student Date

____
Relationship to student

____
Street Address

____
City State Zip

Requestor:______________________________
Requestor's phone number: ______________________

*If the student's records contain any of the following information, that student or student's authorized representative must express written consent.

WAC 392-172-422
WAC 392-172-102 & 104
RCW 70.02.005-904

☐ HIV/Aids status, diagnosis, treatment (age 14 or older)
☐ Alcohol/drug treatment (age 13 or older)
☐ Family planning/abortion (no minimum age)
☐ Mental health services (age 13 or older)

____
Signature of student or authorized student representative Date