PO Box 2098
Everett, WA 98213
www.everettsd.org

NOTE: *To be used with **CAREGIVERS** of EPS students*

Authorization for Release/Exchange of Information

Name: **DOB:**

Phone Number:

I consent to the use and disclosure of confidential information about me within Everett Public Schools and with those listed below to coordinate services, treatment, payments, and benefits for me or for other purposes authorized by law. Information may be shared verbally or in writing:

Please check all below who are included in this consent in addition to Everett Public Schools and identify them by name:

☐	Health Care Providers:
☐	Mental Health Care Providers:
☐	Substance Use Service Providers:
☐	Tribes:
☐	School Districts or Colleges:
☐	Social Security Administration or Other Federal Agency:
☐	Department of Social and Health Services (DSHS):
☐	Utilities:
☐	Housing:
☐	Department of Children Youth and Families (DCYF):
☐	Other*:*
☐	Other*:*
☐	Other*:*

I authorize and consent to sharing the following records and information (check all that apply):

☐ All my client records
☐ School, education, and training
☐ Other:
☐ Healthcare information
☐ Treatment or care plans
☐ Family, social and employment history
☐ Only the following records: _____

I acknowledge notification of this transfer of records as required by the Family Educational Right and Privacy Act of 1974 and understand that I have a right to receive a copy at my own expense if requested and to contest any information I feel is incorrect. This medical authorization is valid for the academic year for the stated reasons of the request unless revoked in writing. All records received will become part of the student's file. I understand that once the health information I have authorized to be disclosed reaches the noted recipient, that person or organization may re-disclose it, at which time it may no longer be protected under Privacy laws. I can cancel this authorization at any time in writing. I understand that once the information has been released according to the terms of this authorization, the information cannot be recalled.

Printed Name **Signature** **Date**

Name of Requestor **Title** **Requestor Signature** **Date**

**If the individual's records contain any of the following information, that individual or authorized representative must express written consent by checking below and signing

☐ HIV/Aids status, diagnosis, treatment (age 14 or older)
☐ Family Planning/abortion (no minimum age)
☐ Alcohol/drug treatment (age 13 or older)
☐ Mental Health Services (age 13 or older)

Signature Date