EVERETT PUBLIC SCHOOLS
Student Support Services Department
PO Box 2098
Everett, WA 98213
www.everettsd.org

AUTHORIZATION FOR EXCHANGE OF CONFIDENTIAL MEDICAL INFORMATION

Date :

Student Name:	Birth Date:
School:	Grade:

I hereby authorize the exchange of confidential records regarding the above named student between:

Everett Public Schools and Name of agency/physician/counselor/, etc Street Address City, State, Zip Phone FAX number	Names of staff that will have my permission to access this information: Nurse: Teacher: School Psychologist: Other: Other:

Specific Information Requested:

and other information relevant to educational service.

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**."*

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 ninety (90) days unless revoked in writing. All records received will become part of the student's confidential special education 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

Please return to:

Requestor:

School:

Address:

City/State/Zip :

_____
Requestor Signature

_____ _____
Parent/Guardian/Adult student Signature Date

_____
Relationship to student

_____
Street Address

_____ _____ _____
City State Zip

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