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

Authorization for Release/Exchange of Information

Student Name: _____ **DOB:** _____

School: _____ **Grade:** _____

I hereby authorize the release/exchange of confidential educational, medical, and/or mental health information for the above-named student.

1. Organization(s) or person(s) allowed **to release** the information indicated by this form:
   - ☐ Everett Public Schools
   - ☐ Other: Name: _____ Address: _____
     Phone: _____ Fax: _____

2. Organization(s) or person(s) **to receive** the information indicated on by this form:
   - ☐ Everett School District
   - ☐ Other: Name: _____ Address: _____
     Phone: _____ Fax: _____

3. Specific description of the educational, medical, and/or mental health information that may be used or disclosed:
   - ☐ Report Card/Transcript/Attendance
   - ☐ Current IEP & Evaluation Reports
   - ☐ Behavior Report
   - ☐ Educational Assessment Report
   - ☐ Hospital or Clinic Report/Records
   - ☐ Health Records/Immunizations
   - ☐ Occupational Therapy Report
   - ☐ Physical Therapy Report
   - ☐ Speech/Language Report
   - ☐ Psychological Report
   - ☐ Health/Medical Social Report
   - ☐ Other:

4. The information will be used or disclosed for the following purpose(s):
   - ☐ At the request or direction of the undersigned individual
   - ☐ To plan an appropriate educational program addressing special needs and/or attendance
   - ☐ Other: _____

5. 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.

_____ _____
Name of Parent/Guardian **Relationship to Student**

_____
Parent/Guardian/Adult Student Signature | Date

_____ _____
Name of Requestor and Title **Requestor Signature** **Date**

**If the student's records contain any of the following information, that student or student's 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)

_____
Student or Authorized Representative Signature | Date