



**AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION**

Patient/Student Name \_\_\_\_\_ Birthdate \_\_\_\_\_

**Section I – Information Requested**

Name/Agency \_\_\_\_\_

Person Disclosing Information \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_

Phone \_\_\_\_\_ FAX \_\_\_\_\_ Date Records Requested \_\_\_\_\_

**INFORMATION TO BE RELEASED:**

Specific nature of information to be disclosed: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

For the purpose of: \_\_\_\_\_

**Section II – Authorization**

I hereby authorize the release of health information as described in Section I to the individuals who are affiliated with the school/agency indicated in Section III. I understand that these records, once received by the school district, may not be protected by the HIPAA Privacy Rule, but will become education records protected by the Family Educational Rights and Privacy Act. I understand that my consent for release of records is voluntary and I can withdraw my consent at anytime in writing. Should I withdraw my consent, it does not apply to information that has already been provided under the prior consent for release of information.

This authorization is valid for 90 days. The expiration date is \_\_\_\_\_.

**Parent/guardian signature** \_\_\_\_\_ **Date** \_\_\_\_\_

**Student signature\*** \_\_\_\_\_ **Date** \_\_\_\_\_

\*If a minor student is authorized to consent to health care without parental consent under federal or state law, only the student shall sign this authorization form. In Washington, a minor, depending on age, can consent to outpatient mental health care, alcohol and drug treatment, HIV/AIDS status-diagnosis/treatment, and reproductive health care services.

**Section III – Receiving Agency Information**

School/Agency \_\_\_\_\_

Address \_\_\_\_\_

\_\_\_\_\_

School Nurse \_\_\_\_\_

School Psychologist \_\_\_\_\_

Other \_\_\_\_\_

\_\_\_\_\_

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 medical or other information is not sufficient. See chapter 70.02 RCW.

Envelope shall be marked “**CONFIDENTIAL**”

*Persons needing this publication in an alternative format, please contact the ADA/504 Coordinator,  
Assistant Superintendent, Department of Learning and Teaching, 425-204-2318*

**Distribution:** White: Person Disclosing Information    Yellow: Confidential Health Record Folder