HIGHLINE PUBLIC SCHOOLS

Purpose: Your child has been identified as having a possible health/psychological/educational need. The purpose of this form is to allow Highline Schools staff to obtain health care records that will be used in establishing an appropriate plan of care and possible future educational services for your child. As a parent/guardian you have the right to give or not give permission for the release of your child' health care records.

AUTHORIZATION FOR MUTUAL EXCHANGE OF CONFIDENTIAL MEDICAL INFORMATION

Student's Name: _____ Birth date: _____

Name of School _____ I authorize my child's records to be faxed Initials _____

INFORMATION TO BE EXCHANGED WITH:

Provider/Agency _____ Telephone Number _____

Address _____ Fax Number _____

City _____ State _____ Zip Code _____

Highline School District employees authorized to exchange information:

☐School Nurse Name: _____ ☐Psychologist Name _____

☐Other: _____ ☐Other: _____

Parent initials required below indicating information to be released

_____ Clinic/Hospital records & evaluations _____Other _____

_____Laboratory/X-ray/diagnostic reports _____ Exclusions _____

PURPOSE OF DISCLOSURE: ☐Educational Planning ☐Nursing Care Planning ☐Other_____

This authorization will expire one year from the date signed below unless another date or event is entered here _____.
I understand that authorizing the disclosure of this health information is voluntary. I understand that 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, that the information cannot be recalled and will not affect any actions already taken by the health care provider based on this authorization. I understand that any disclosure of information carries with it the potential for further release or distribution by the recipient that may not be protected by federal confidentiality rules, but will become education records protected by the Family Educational Rights and Privacy Act. I understand that I do not have to sign this authorization in order to get health care benefits (treatment, payment, enrollment or eligibility for benefits).

Print Name _____ Signature _____ Date _____

To those receiving information under this authorization: This information disclosed to you is protected by state & 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 70.02.005-904RCW.
Envelope should be marked "**CONFIDENTIAL**"

➡ If the student is older than age indicated below, and records contain any of the following information, only the student's signature/consent is required.

☐ HIV/AIDS status, diagnosis, treatment (age 14 or older)
☐Alcohol/drug treatment (age 13 or older)
☐Family Planning/Sexually Transmitted Diseases (age 13 or older)
☐Mental Health Services (age 13 or older)

_____
Signature of student or authorized student representative

_____
Date

Please send the information to:

☐Highline School District - Central Files

Attn: _____
15675 Ambaum Boulevard S.W.
Burien WA 98166

Please send the information to: Mark Confidential

_____ School

Attn: _____

_____

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