HIGHLINE PUBLIC SCHOOLS

Authorization for Exchange of Confidential Education and Medical Information

Student's Name:_____ Birthdate:_____

School:_____ Grade:_____

I authorize the exchange of confidential education or health records regarding the above named student for the purpose of: ☐ Establishing special education eligibility, program planning; ☐ Healthcare treatment planning; ☐ Prevention/intervention service planning; or ☐ Other_____.

INFORMATION TO BE SHARED WITH:

Party (provider, agency, etc.):_____ Telephone:_____

Address:_____ Fax:_____

City:_____ State:_____ Zip:_____

DISTRICT STAFF WHO MAY SHARE INFORMATION (if applicable):_____

Education Records Requested (Check all that apply)

☐ Official Transcript	☐ Social/Emotional
☐ Academic Records	☐ Discipline Records
☐ Educational Evaluations/Test Scores	☐ Psychological and Counseling Records
☐ Special Education Records	☐ Other (Specify):_____

Health Records Requested (Check all that apply)

☐ Clinic/Hospital Records & Evaluations	☐ Other (Specify):_____
☐ Laboratory/X-Ray/Diagnostic Reports	☐ Exclusions (Specify):_____

STUDENT CONSENT: If health records contain any of the following information, only student consent is required if the student is the appropriate age. The respective age is listed after each category of health information. (Check all that apply)

☐ HIV/AIDS status, diagnosis, treatment (14+)	☐ Family planning/Sexually Transmitted Disease (13+)
☐ Alcohol/Drug Treatment (13+)	☐ Mental health services (13+)

ACKNOWLEDGMENT: I acknowledge notification of this transfer of educational or health records as required by the Family Educational Right and Privacy Act ("FERPA") and the Health Insurance Portability and Accountability Act ("HIPPA"), and understand that I have right to receive a copy of the produced records at my own expense. I may request a hearing to challenge the content of any education records. This authorization is entered into voluntarily, and I understand that I may revoke it at any time, in writing. I understand that once information has been released pursuant to this authorization, the information may not be recalled and will not affect actions already taken by the parties who received records authorized to be distributed. I understand that any disclosure of information carries the potential of further release by the recipient, provided that said disclosure will comply with Washington law, FERPA, and HIPPA, as applicable. I also understand that this authorization does not impact my ability to receive health care treatment, services, enrollment, or eligibility for benefits. This authorization will expire the end of each school year unless another date or event that is sooner is entered here _____.

CONFIDENTIALITY: Any party receiving records pursuant to this authorization acknowledges that the information disclosed is protected by state and federal law. You may not release it to any party not listed in this form without written consent of the authorizing party. A general authorization for release is insufficient. *See* RCW 70.02, *et seq.*

(PARENT) Print:_____ Sign:_____ Date:_____

(STUDENT)Print:_____ Sign:_____ Date:_____

Send information to:
Highline School District – Central Files
Attn:_____
15675 Ambaum Blvd. S.W.
Burien, WA 98166

Send information to (Marked "**CONFIDENTIAL**")
_____
Attn:_____
_____
_____