Renton SCHOOL DISTRICT
SERVICE | EXCELLENCE | EQUITY

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. I do not need to sign this form in order to assure treatment or payment. I can revoke my authorization at any time by writing to Kohlwes Education Center, but that will not affect information already disclosed. Information disclosed through this authorization may be re-disclosed and is no longer protected by HIPAA. This authorization will expire one year from the date signed below unless another date or event is entered here _____.

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