Issaquah Public Schools
5150 220th Ave SE
Issaquah WA 98029
425-837-7000

Authorization for Release of Medical Records and/or Exchange of Information

PURPOSE: As a parent, guardian or student, you have the right to give permission or not give permission for the release of your child's records with other persons or agencies. This request provides you with the opportunity to approve or not approve such a request unless release of records is allowed under one of the exceptions under the rules implementing the Family Education Rights and Privacy Act, FERPA, (for example, transfer of records from one school district to another).

Student Name: _____ Date: _____
Student DOB: _____ Parents/Guardian: _____

I hereby authorize the release of records:

From: _____ To: _____
(*Name of agency/person)* *(Person/Agency Making the Request)*

_____ _____
Street Address *Street Address*

_____ _____
City, State, Zip *City, State, Zip*

_____ _____
Phone *Phone*

_____ _____
Fax *Fax*

Describe the records to be disclosed:

☐ Health Records
☐ Psychological and Counseling Records
☐ Special Education Records
☐ Transcripts
☐ Communication/Exchange of information between agency and school
☐ Other (specify): _____

Release Requiring Specific Consent: Specific consent is required for release of the following information. Student consent is also required at the ages specified in parentheses below. Mental health records are protected under RCW 71.05.390 and Chapter 21.34 RCW. Drug and alcohol abuse and treatment records are protected under 42 C.F.R. §2; Information related to HIV/AIDS or sexually transmitted diseases is protected under RCW 70.24.105.

I specifically authorize the release of records relating to:

☐ Reproductive care (student consent always required)
☐ Sexually Transmitted Diseases or HIV/AIDS (age 14 and older)
☐ Mental Health/Illness (age 13 and older)
☐ Drug/Alcohol Abuse (age 13 and older)

The reason for disclosing the record(s) is:

☐ An Evaluation or Reevaluation Process
☐ A Program Review
☐ An IEP is Being Developed
☐ Other (specify): _____

I understand and acknowledge the following:

- Released information will be treated in a confidential manner by the school district under the provisions of the Family Education Rights and Privacy Act (FERPA). FERPA prohibits disclosure of personally identifiable information without consent except in limited circumstances. If the request is for health or medical information, the medical information received by the district is protected under FERPA privacy standards by a school district and not the Health Insurance Portability and Accountability Act (HIPAA).
- The information released in response to this authorization may be re-disclosed to other parties.
- I do not need to sign this form to assure treatment or payment. My treatment, payment, enrollment in any health plan, or eligibility for benefits is not conditioned on signing this authorization form.
- My consent for the release of records is voluntary and I can withdraw consent at any time, except to the extent that information has already been released in reliance upon this authorization. Revocation must be in writing.

This authorization is valid from _____/____/_____ to _____/____/_____.
Note: If no date is specified above, authorization will expire one year from the date of the signature below.

_____ _____ _____ _____
Parent/Guardian Signature Date Student Signature Date