MEAD SCHOOL DISTRICT

HEALTH SERVICES

2323 E. Farwell Rd • Mead WA 99021 • Telephone (509) 465-6000 • Fax (509) 465-6020

AUTHORIZATION FOR RELEASE OF HEALTH CARE INFORMATION

Patient/Student Name _____ Birthdate _____ School _____

I authorize the release of information described below to be released FROM and TO the following:

Information to be released FROM:

_____
Name of Facility/Agency/Provider *Phone*

_____
Address

_____
City, State, Zip Code

Information to be released TO:

_____
Name of Recipient

_____
Name of Recipient

_____
Name of Recipient

_____
Address

_____
City, State, Zip Code

_____
Phone

Specific information to be released: _____

Purpose for which disclosure is being made: _____

_____

My Rights *I understand the following: I do not have to sign this authorization in order to obtain health care benefits (treatment, payment, enrollment, or eligibly for benefits). I have a right to request and receive a Notice of Privacy Practices from the above named provider. I may inspect and receive a copy (a nominal fee may be charged). Unless the purpose of this authorization is to determine payment of a claim or benefits, the requesting entity will not condition the provision of treatment or payment for my care on my signing the authorization. I can revoke this authorization at anytime in writing, but the revocation will not apply to information already used or disclosed. I recognize that this information, once received by the school district, may no longer be protected by the HIPPA Privacy Rule and become educational records protected by the Family Education Rights and Privacy Act (FERPA), but will be handled in compliance with applicable state and federal laws and school district policies and procedures. The provider must make the healthcare information available within 15 working days after receiving the request or notify the patient of any delay (RCW 70.02.080).*

This authorization expires with the end of the school year on ___/___/___, whichever is sooner.

_____ _____
Parent Signature/Legal Representative Date Student Signature * Date

*****If the student is a minor, but is authorized to consent to health care without parental consent under federal and state laws, only the student shall sign this form.

- ☐ HIV/AIDS, STDs status, diagnosis, treatment (consent may be given by student 14 years of age)
- ☐ Family planning/abortion (consent may be given by any age student)
- ☐ Alcohol/drug treatment (consent may be given by student 13 years of age)
- ☐ Mental health services (consent may be given by student 13 years of age)