Mercer Island School District

Authorization for Request of Records and Mutual Exchange of Information

Purpose: As a parent, guardian or student, you have the right to give or deny permission for the release or exchange of your/child's records with other persons or agencies. This document allows you to approve or deny such a request, unless release of records is allowed under one of the exceptions to the *Family Education Rights and Privacy Act* (FERPA), e.g., transfer of records from one school district to another.

Student Name:________________________________DOB:_________School ____

I hereby authorize the release of records:

To/From: Mercer Island School District
(Name of agency/person)

____
(Street Address)

____
(City, State, Zip)

____
(Phone/Fax)

To/From: ______________________________
(Name of person)

____
(Street Address)

____
(City, State, Zip)

____
(Phone/Fax)

Information to be disclosed:

□ All records regarding this student □ Completion of Physician Evaluation Form □ Mental health records

□ Counseling records □ Drug/Alcohol records □ Test scores and protocols

□ Consultation (verbal) □Other: ____

The reason for disclosing the record(s) is:

____

Records obtained in response to this request become subject to the federal *Family Education Rights and Privacy Act of 1974* (FERPA), which requires prior written consent from the parents of the students before the records may be shared with any other party, except in the case of student transfer to another school system. FERPA also assures parent access to the records of the student upon their request. Please note that if the request is for health or medical information, the medical information received by the district is protected under FERPA privacy standards and not the *Health Insurance Portability and Accountability Act* (HIPAA).

I understand that the information obtained will be treated in a confidential manner by the school district under the provisions of the FERPA, which prohibits disclosure of personally identifiable information without consent except in limited circumstances. I understand that my consent for the release of records is voluntary and that I may withdraw my consent at any time in writing. Should I withdraw my consent, it does not apply to information that has already been provided under the prior consent for release.

Authorization is provided until____________________or for **one calendar year** from date of signature, if not otherwise specified. (Note: for release of medical records, the authorization can be no longer than 90 days from date of signature.)

____ ______________________________
(Parent/Guardian/Adult Student Signature) (Date)

Student Signature:____ Date: ___________________________________
(Required for release of all drug/alcohol records; mental health records for students 13 years or older; HIV/STD records for students 14 years or older. Preferred but not required in other cases.)

Date records requested: ____________________

revised 5/14