Steilacoom Historical School District
511 Chambers Street
Steilacoom, WA 98388
Telephone: (253) 983-2200 Fax: (253) 584-7198

Authorization for Mutual Exchange of Education/Health Information

Patient/Student Name: _____ DOB: _____

I hereby authorize _____ (health care provider name &title)

and _____ (name & title of school official) to exchange health and education information/records for the purpose listed below.

_____ (address & telephone of school/school district)

_____ (address & telephone of health care provider)

Describe records to be disclosed:

The reason for disclosing the record(s)

- ☐ 1. Educational evaluation and program planning.
- ☐ 2. Health assessment and planning for health care services and treatment in school.
- ☐ 3. Medical evaluation and treatment.
- ☐ 4. Other: _____

_____

I, the Parent/Legal Guardian of the above named student, do hereby request that the following educational/medical information regarding this student be mutually shared with the school named on this form. Depending on my student's age and the nature of the confidential medical information being requested, a parent, legal guardian, and/or student's signature is required for the release. I understand that my permission expires on (Month/Day/Year)_____ or 90 days after the date this form is signed. I can cancel this at any time, but I understand that the cancellation will not affect any information that was already released before the cancellation.

I hereby authorize the mutual release/exchange of records:

Parent/Guardian/Student Signature: _____ Date: _____

To those receiving information under this authorization: The information disclosed to you is protected by state and federal law. You are not authorized to release it to any agency or person not listed on this form without specific written consent of the person to who it pertains. A general authorization for release of medical or other health information is NOT sufficient. See Chapter 70.02 RCW, and the Family Educational Rights and Privacy Act (FERPA) regulations.