



Authorization for Release of Records

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.

I hereby authorize the release of records:

Student/Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Date: \_\_\_\_\_

Request to: \_\_\_\_\_ Request From: \_\_\_\_\_

(Person of Attention: Respondent) (Person of Attention: Requestor)

Name of agency North Thurston Public Schools

Street Address 305 College Street

City, State, Zip Lacey, WA 98516

Phone 360.412.4482

Fax 360.412.4557

Describe the records to be disclosed:

- Health Records Transcripts
Psychological and Counseling Records Communication/exchange of information between agency & school
Special Education Records All of the above

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.

- I specifically authorize the release of records relating to:
Reproductive Care (student consent always required) Mental Health/Illness (age 13 and older)
Sexually Transmitted Diseases or HIV/AIDS (age 14 and older) Drug/Alcohol Abuse (age 13 and older)

The reason for disclosing the record(s) is:

- An Evaluation or Reevaluation Process An IEP is Being Developed
A Program Review All of the Above

To those receiving information under this authorization: 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.

By signing this release of records authorization, I understand that the provider of such records or information cannot guarantee or assure that such records or information will not be further released or re-disclosed to third parties by the recipient.

I understand that I can cancel this authorization at any time by writing to the Special Education or Health Information Management Department. I understand that once the information has been released according to the terms of this authorization, the information cannot be recalled, and that authorizing the disclosure of this health information is voluntary.

This authorization is valid from \_\_\_\_\_ to \_\_\_\_\_.

Parent/Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_