Student Name:

Student ID:
WA SSID:
Date of Birth:

Lake Washington School District

16250 NE 74th Street
PO Box 97039
Redmond, WA 98073-9739
425.936.1200

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. 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).

Date: _____ Parent(s): _____

I hereby authorize the release of records:

Request To:	Request From:
(Name of agency/person)	*(Person/Agency Making the Request)*
Street Address	*Street Address*
Street Address	*Street Address*
City, State, Zip	*City, State, Zip*
Phone, Fax	*Phone, Fax*
Email	*Email*

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 71.34 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):_____

By signing this medical records or information disclosure 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 also understand that the provider cannot guarantee that such records or information remain protected by federal or state law. I understand that when such records or information are provided to a school district where my student is enrolled, further disclosure of such records or information no longer protected by the Health Insurance Portability and Accountability Act (HIPAA), may nevertheless be regulated under other federal law (such as the Family Educational Rights and Privacy Act of 1974 (FERPA)) or corresponding state law.

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. A general authorization for release of information is not sufficient. See Chapter 70.02.005-904 RCW. *Envelope should be marked "CONFIDENTIAL."*

This authorization will expire one year from the date signed below. I understand that my consent is voluntary and I can withdraw my consent at any time in writing. Should I withdraw my consent, it does not apply to information that has already been provided prior to withdrawing my consent.

Parent/Guardian Signature	Date	Student Signature	Date