



**AUTHORIZATION FOR RELEASE OF CONFIDENTIAL  
MEDICAL RECORDS FOR SCHOOL USE ONLY**

**Student Name:** \_\_\_\_\_ **Birth Date:** \_\_\_\_\_

**School:** \_\_\_\_\_

**Information Requested From:**

Licensed Health Care Provider: \_\_\_\_\_

Clinic Name: \_\_\_\_\_

Clinic address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Clinic Phone #: \_\_\_\_\_ FAX #: \_\_\_\_\_

I hereby authorize the release of medical information as described below to the following individuals:

|                            |
|----------------------------|
| School Psychologist: _____ |
| District Nurse _____       |
| Special Ed Teacher         |
| Staff Name, Title          |
| Staff Name, Title          |
| Staff Name, Title          |

**Please send records to:**

Cheney School District  
Student Support Services  
12414 S Andrus Rd  
Cheney, WA 99004

**FAX: 509-559-4507**  
**PH: 509-559-4517**

**Specific nature of information to be disclosed: Exchange of oral and written information r/t accommodations needed at school as well as diagnosis and or**

**\*\*Specific Minor Patient Authorization**

If the patient/student has reached the age below, only the patient/ student can authorize disclosure relating to the following\*:

- |                                                   |                                                          |
|---------------------------------------------------|----------------------------------------------------------|
| ____ HIV/AIDS, STD's 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 must be given by student 13 years of age)       |
| ____ St. Lukes Rehabilitation Institute           | (consent must also be signed by student 14 years of age) |

**My Rights** I understand the following: I do not have to sign this authorization in order to get health care benefits (treatment, payment, enrollment, or eligibility 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 any time 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 HIPAA 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 procedure. The provider must make the health care information available within 15 working days after receiving the request or notify the patient of any delay (RCW 70.02.080).

This authorization is valid from the date of the signature to the last day of the current school year.

Date \_\_\_\_\_ Signature \_\_\_\_\_  
(Parent/Guardian) (Relationship to Patient)

Date \_\_\_\_\_ Signature \_\_\_\_\_ Patient \_\_\_\_\_  
(Student/Patient(\*\*if applicable and over 13))