Authorization for Exchange of Medical Information

SECTION I – INFORMATION REQUESTED FROM

NAME:

AGENCY:

ADDRESS: _____

_____

_____

NAME OF PERSON DISCLOSING INFORMATION:

TITLE:

Name of Student: Birth Date: Date:

Specific nature of information to be disclosed: _____

_____

_____

_____

_____

SECTION II – AUTHORIZATION

I hereby authorize the release of medical information as described in Section 1 to the individuals who are affiliated with the school/agency indicated in Section III.

This authorization expires on: _____

_____
Parent Signature Date

_____
Student Signature Date

If the student is a minor authorized to consent to health care without parental consent under federal and state law, only the student shall sign this authorization form.

SECTION III – AGENCY RECEIVING INFORMATION

AGENCY/SCHOOL: Orting High School

NAME/POSITION (Nurse, Administrator, etc.)

_____

_____

ADDRESS: 121 Whitesell St. NE,

Orting, WA 98360

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 medical or other information is not sufficient.

See chapter 70.02 RCW.

Envelope shall be marked “CONFIDENTIAL”.