**Federal Way Public Schools**
**33330-8th Avenue South, Federal Way, WA 98003**
**Phone: 253-945-2000**

# HIPAA AUTHORIZATION FOR EXCHANGE OF MEDICAL INFORMATION

RE: _____ DOB: _____
(Patient's First Name & Last Name) (month day year)

Address: _____ City: _____ Zip: _____

I hereby authorize the following to disclose the protected health information regarding the above-named patient to **Federal Way Public Schools,** 33330-8th Avenue South, Federal Way, WA 98003, for the purpose of educational evaluation and planning.

_____
Name of agency / physician / counselor / etc.

_____
Street Address City, State, Zip

_____
Phone (+ Area Code) FAX number (+ Area Code)

Information obtained with this authorization will be used solely for the purpose defined above and will be limited to the minimum information necessary to achieve the stated purpose.

Information to be disclosed (X all that apply):

☐ Medical Records ☐ Diagnostic Records

☐ Treatment Records ☐ Other _____

By initialing below, I authorize release of the information pertinent to my case:

_____ Chemical Dependency (includes alcohol/drug treatment)
_____ HIV / AIDS
_____ Mental Health Information

I understand that the information used or disclosed may be subject to redisclosure by the person or class of persons or facility receiving it, and would then no longer be protected by federal privacy regulations.

I may revoke this authorization by notifying **Federal Way Public Schools** in writing of my desire to revoke it. However, I understand that any action already taken in reliance on this authorization cannot be reversed; and my revocation will not affect those actions. I understand that the medical provider to whom this authorization is furnished may not condition the treatment of me on whether or not I sign the authorization.

This authorization expires on_____, OR upon occurrence of the following event that relates to me or to the purpose of the intended use or disclosure of information about me: _____.

If this authorization form does not contain an expiration date, it expires 90 days from the date this form was signed.

**PLEASE RETURN TO:**

**Federal Way Public Schools**
**Student Support Services**
**33330-8th Avenue South**
**Federal Way, WA 98003**

Attn: _____

Home School: _____

_____ _____
Signature of parent, guardian, or adult student Date

_____
OR Personal representative's name

Relationship to patient: ☐ Parent ☐ Legal guardian* ☐ Holder of Power of Attorney*

*Attach legal documentation if legal guardian or Holder of Power/Attorney.

_____
Street Address

_____ _____ _____
City State Zip