

LIBERTY SCHOOL DISTRICT
AUTHORIZATION FOR EXCHANGE OF HEALTH CARE AND/OR
EDUCATION INFORMATION

Student #: _____ **School:** _____ **Date:** _____

Student's Name: _____ **Birthdate:** _____

I hereby authorize the exchange of health and/or education information:

Between School District Staff (listed below)

and:

Name of Staff Member

Name of Agency/Individual

District Nurse (509) 245-3211 245-3530

Title Phone Fax

Phone Fax

29818 S. North Pine Creek Road

Spangle WA 99031

Address

Address

Other Staff (if needed)

Title Phone Fax

Specific nature of information to be disclosed: Information regarding his/her diagnosis of: _____

Purpose for which disclosure is being made: Emergency care plan preparation

I hereby authorize the exchange of health care information as described above. 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 procedures.

This authorization expires with the end of the school year or _____, whichever is sooner. I may terminate this authorization in writing at any time. I have a right to a copy of the authorization and may inspect and receive a copy of the disclosed or used information.

Signature of Parent/Legal Representative

Date

Student Signature*

Date

*If the student is a minor but is authorized to consent to health care without parental consent under federal and state laws, only the student shall sign this form (RCW 70.02.030).

___ HIV/AIDS, STD status, diagnosis, treatment

(Consent may be given by student 14 years of age)

___ Family Planning/Abortion

(Consent may be given by student of any age)

___ Alcohol/Drug Treatment

(Consent may be given by student 13 years of age)

___ Mental Health Services

(Consent may be given by student 13 years of age)

(Envelope shall be marked "CONFIDENTIAL")