PASCO SCHOOL DISTRICT #1 – HEALTH SERVICE CENTER
Nursing Department
4403 W Court St. Suite A - Pasco, WA 99301
Phone: (509) 416-7826 x2131 - Fax: (509) 416-7816

Authorization to Release/Obtain/Exchange Patient Health Information

I authorize the following health care provider/clinic to use and disclose a copy of the health information described:

Provider Information

Clinic or Agency Representative:_____

Address:_____ City: _____State:_____ Zip Code: _____

Phone #:(____)_____ Fax #:(____)_____ Email:_____

Patient

Patient Name: _____ Date of Birth: _____/_____/_____
(Legal Name) Last First Middle Month Day Year

Release and Delivery

I authorize the provider and/or clinic to: ☐ Release to ☐ Obtain from ☐ Exchange with (verbal info only)

PSD Representative: _____ School/Building:_____

Address:_____ City: Pasco State: WA Zip Code: 99301

Phone #:(____)_____ Fax #:(____)_____ Email:_____

Please send the records via: ☐ Paper (Mail) ☐ Fax ☐ Email

Purpose

The reason for disclosing the record(s) is for school planning, safety, and _____.

Information

Records for dates from:_____ to:_____ Month/Year Month/Year If no date is specified, only the most recent clinical documentation will be released.	☐ History & Physical ☐ Progress Notes ☐ Diagnostic Reports (lab, x-ray, ECG, etc.) ☐ Discharge Summary ☐ Educational Records ☐ Other (specify)_____
I specifically authorize the above-named health care provider/clinic to release the health information checked:	☐ Reproductive Care ☐ Sexually Transmitted Infections (incl. HIV/AIDS) ☐ Mental health ☐ Drug/Alcohol Abuse

Signatures

This authorization expires one (1) year from the date signed unless another date or event is indicated here:_____

I understand that:

- Signing this release of health information is voluntary.
- A minor's (age 13-17) signature is required below to release information related to reproductive care, mental health conditions, and/or drug and alcohol abuse diagnosis or treatment.
- This information obtained will be treated in a confidential manner by the school district under the provisions of the Family Education Rights and Privacy Act (FERPA). Please note that if the request is for health or medical information, the medical information received by the district is protected under FERPA privacy standards by a school district and not the Health Insurance Portability and Accountability Act (HIPAA).
- I can cancel this authorization at any time by informing Pasco School District's Health Service Center in writing.

_____ _____ _____
Signature of Minor Patient Printed Name Date Signed

_____ _____ _____
Signature of Patient/Legal Representative Printed Name Date Signed

_____ (____)_____
Relationship to Patient Phone Number