



# Fife School District No. 417

1720 Oak Street, Milton WA 98354

## CONSENT FOR MUTUAL RELEASE AND/OR EXCHANGE OF CONFIDENTIAL HEALTH INFORMATION

Student Name \_\_\_\_\_ Birthdate \_\_\_\_\_ Grade \_\_\_\_\_

Legal Name \_\_\_\_\_ Age \_\_\_\_\_  
(If different)

Early Learning Center  Discovery Primary  Hedden Elementary  Fife Elementary

Surprise Lake Middle School  Columbia Junior High  Fife High School

I hereby authorize the exchange of confidential information with the agency/person(s) listed below:

### ATTENTION:

\_\_\_\_\_  
**Health Care Provider/Agency**

\_\_\_\_\_  
Name/Position – Fife School District

\_\_\_\_\_  
Street Address

\_\_\_\_\_  
Administrative Office/Street Address

\_\_\_\_\_  
City, State, Zip Code Phone

\_\_\_\_\_  
City, State, Zip Code Phone

\_\_\_\_\_  
Fax Number

\_\_\_\_\_  
Fax Number

### Information to be exchanged with:

Parent, Guardian, and/or Adult Student initials required below indicating information to be released.

Clinical and Hospital records & evaluations

Laboratory, X-Ray, and Diagnostic reports

Educational records

Other \_\_\_\_\_

Other \_\_\_\_\_

Parent, guardian, and/or adult student is requesting that the following information be excluded in this request.

\_\_\_\_\_  
This authorization is valid ninety (90) days from the date signed. I understand that authorizing the disclosure of this health information is voluntary. I understand that I can cancel this authorization at any time in writing. I understand that once the information has been released according to the terms of this authorization, that the information cannot be recalled. I understand that any disclosure of information carries with it the potential for further release or distribution by the recipient that may not be protected by federal confidentiality rules.

\_\_\_\_\_  
Signature of Parent, Guardian, and/or Adult Student Date

Notice To those receiving information under this authorization: This information disclosed to you is protected by state & 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 information is not sufficient. See Chapter 70.02.005-904RCW. Envelope should be marked "CONFIDENTIAL".

**Page Two – Please have student initial and sign if age 13 or older**

If the student is older than age indicated below, and records contain any of the following information, the student's signature and consent is required.

- HIV/AIDS status, diagnosis, treatment (age 14 or older)
- Alcohol and/or drug treatment (age 13 or older)
- Family planning and/or sexually transmitted diseases (age 13 or older)
- Mental Health services (age 13 or older)

\_\_\_\_\_  
Signature of student or authorized representative Date

Notice: If this authorization has been requested by the school district in conjunction with an agreement by the district to pay for medical services or assessments, and those services or assessments are for the sole purpose of creating health information for use by or disclosure to the school district, the health care provider may condition the provision of health care on the signing of this authorization, pursuant to 24 C.F.R. 164.508(b)(4)(iii). A health care provider may not otherwise condition treatment, payment, enrollment or eligibility for benefits on the signing of this authorization. School District employees authorized to exchange information: