PASCO SCHOOL DISTRICT #1

Special Services Department

1215 W Lewis St, Pasco, WA 99301
SpedRecords@PSD1.org
P: 509-543-6703 • Fax: 509-546-6706

AUTHORIZATION FOR MUTUAL EXCHANGE OF RECORDS

As a parent, guardian or student, you have the right to give permission or not give permission for the release of your child's records with other persons or agencies. This request provides you with the opportunity to approve or not approve such a request unless the release of records is allowed under one of the exceptions under the rules implementing the Family Educational Rights and Privacy Act, FERPA, (for example, transfer of records from one school district to another).

Student Demographics
Student Name: _____
Date of Birth: _____
Student ID (optional): _____

Method of Delivery
☐ *In-person pickup* ☐ *Fax*
☐ *Mail* ☐ *Email*

Person authorizing release/request (Photo ID Required)
Parent/Guardian or Student Name: _____
Address: _____
Relationship to Student: _____
Phone Number: _____
Email (optional): _____

I understand that this information obtained will be treated in a confidential manner by the school district under the provisions of Family Education Rights and Privacy Act (FERPA). FERPA prohibits the disclosure of personally identifiable information without the consent except in limited circumstances. 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). This authorization is valid from ___/___/___ to ___/___/___. Note: For release of information records, the authorization can be no longer than 90 days safter thus authorization is signed. I understand that my consent for the release of records is voluntary, and I can withdraw my consent anytime in writing. Should I withdraw my consent, it does not apply to information that has already been provided under the prior consent for release.

_____ _____
Parent/Guardian or Student Signature ***Date***

Reason for Disclosing Records
☐ *Parent/Guardian Request / personal records* ☐ *Transfer to another school/district* ☐ *Medical provider*
☐ *Educational evaluation* ☐ *Other:* _____

☐ ***Authorization to Release Records***

I authorize Pasco School District Special Services Department to release the following records:
☐ *Evaluation Reports*
☐ *IEPs (Individualized Education Programs)*
☐ *All Special Education Records*
☐ *Other:* _____

Release Records To:
Name of Person/ Agency: _____
Address: _____
Email/Fax: _____
Phone #: _____

☐ **Authorization to Request Records**

I authorize Pasco School District Special Services Department to request the following records:
☐ *Evaluation Reports*
☐ *IEPs (Individualized Education Programs)*
☐ *All Special Education Records*
☐ *Other:* _____

Request Records From:
Name of Person/ Agency: _____
Address: _____
Email/Fax: _____
Phone #: _____

DISTRICT USE ONLY
Date Request Received: _____ Staff Initials: _____
Date Records Provided: _____ Staff Initials: _____ Method Sent: _____