AUTHORIZATION FOR RELEASE OF HEALTH CARE AND/OR EDUCATION INFORMATION

Student #: ____ **Date:** _______________

Student's Name: ____

Birth date: ________________________ **Grade/School:** ________

I authorize the release of the information described below to be released FROM and sent TO the following:

Information to be released FROM:

____
Name of facility/agency or provider

____
Address

____
City, State, Zip Code

____
Phone

Information to be released TO:

____
Name(s) of recipient(s)

____
Name(s) of recipient(s)

____
Name(s) of recipient(s)

____
Address

____
City, State, Zip Code

____
Phone

Specific information to be released: ____

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____

Purpose for which disclosure is being made: ____

____

____

Specific Minor Patient Authorization

If the patient/student has reached the age below, only the parent, student, or legal guardian can authorize disclosure relating to the following*:

___HIV/AIDS, STD'S status, diagnosis, treatment (consent may be given by student 14 years of age)
___Family planning/abortion (consent may be given by any age student)
___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)

My Rights I understand the following:
I have a right to request and receive a Notice of Privacy Practices from the above named provider. I may inspect and receive a copy (a nominal fee may be charged). Unless the purpose of this authorization is to determine payment of a claim or benefits, the requesting entity will not condition the provision of treatment or payment for my care on my signing the authorization. I can revoke this authorization at any time in writing but the revocation will not apply to information already used or disclosed. I recognize that this information, once received by the school district, may no longer be protected by the HIPPA 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 procedure. The provider must make the health care information available within 15 working days after receiving the request or notify the patient of any delay (RCW 70.02.080).

This authorization is valid from ____/____/____ to ____/____/____.
Note: For release of health care info/medical records, the authorization will *expire 90 days from the date signed*.

____ ______________________
Signature of parent/legal representative (or student* if appropriate) Date

____ ______________________
Relationship to patient Phone Number