# AUTHORIZATION FOR EXCHANGE OF HEALTH CARE AND/OR EDUCATION INFORMATION

**Student #:** ________________________________________________ **Date:** ________________
**Student's Name:** ___________________________________________
**Date of Birth:** ____________________________ **Grade/School:** ______________________________

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

**Between School District Staff (listed below):** **and:**

| | |
|---|---|
| ___________________________ | ___________________________ |
| *Name of Staff Member* | *Name(s) of Agency/Individual* |
| ________ ________ | ___________________________ |
| *Title* *Phone/Fax* | *Phone/Fax* |
| ___________________________ | ___________________________ |
| *Address* | *Address* |
| ___________________________ | ___________________________ |
| *City, State, Zip Code* | *City, State, Zip Code* |
| ___________________________ | |
| *Other EVSD staff (if needed)* | |
| ________ ________ | |
| *Title* *Phone/Fax* | |

**Specific information to be released**: ___________________________________________________________
______________________________________________________________________________
______________________________________________________________________________

**Purpose for which disclosure is being made**: ______________________________________________
______________________________________________________________________________
______________________________________________________________________________

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/guardian Date Student Signature* Date

## Specific Minor Patient Authorization

*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'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) |

**(Envelope shall be marked "CONFIDENTIAL")**