Shoreline School District
Shoreline, Washington 98155-2148

AUTHORIZATION FOR EXCHANGE OF CONFIDENTIAL MEDICAL INFORMATION

To Parents: We can help you better if we are able to work with health care providers and agencies that know you and your family. By signing this form, you are giving permission for these individuals, clinics, or organizations to share information with those school personnel authorized by you.

Date _____ Student _____ Birthdate _____ Grade _____

Parent _____ Phone _____ School _____

I hereby authorize the exchange of confidential medical records regarding the above named student for the purpose of educational planning and needs assessment between the Shoreline School District and:

Name of physician/agency/other	Name of physician/agency/other
Address	Address
Phone number FAX number	Phone number FAX number

I understand that my express consent is required to release any health care information relating to testing, diagnosis, and/or treatment for HIV/AIDS, sexually transmitted diseases, psychiatric disorder/mental health, or drug and/or alcohol use. I understand that (1) this release, unless limited by me in writing, extends to all aspects of treatment as listed below; (2) I may give written cancellation of this release at any time, but this cancellation will not affect any information that was released before the cancellation; (3) information disclosed under this authorization may be re-disclosed by the recipient and may no longer be protected by the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Records received by the Shoreline Public Schools, however, are protected from re-disclosure under the Family Education Rights to Privacy Act (FERPA). (4) this release, unless cancelled previously, expires upon student separation from the district or on the date indicated below.

Initial**	Information Requested (**Initial all that apply)	
	Medical records	
	Mental health services; including psychiatric information	[13 years of age: student consent required]
	Alcohol/drug information/treatment	[13 years of age: student consent required]
	Family planning/abortion	[student consent required]
	HIV/AIDS status, diagnosis, treatment	[14 years of age: student consent required]
	Other, as listed:	

☐ **If this box is checked, signature provides consent for an Individual Health Plan/Medical 504 evaluation.**

PLEASE RETURN TO:	**This release expires upon student separation from Shoreline SD or this date:** _____
	I give consent for the information requested on this form to be FAXed to the above named school.
Name/Position	
Address	Parent/Guardian/Adult student signature Date
Phone number FAX number	Student signature, if required
	Address

Rev: 10/18