

AUTHORIZATION FOR EXCHANGE OF MEDICAL INFORMATION

SECTION I – INFORMATION REQUESTED FROM

NAME/AGENCY	NAME OF PERSON DISCLOSING INFORMATION
ADDRESS	TITLE

SECTION II - AUTHORIZATION

I hereby authorize the release of medical information as described in section I to the individuals who are affiliated with the school/agency indicated in section III.

This authorization expires 90 days after the date it is signed.

This authorization expires on: _____

_____ Date
Parent Signature

_____ Date
Student Signature*

If the student is a minor but is authorized to consent to health care without parental consent under federal and state law only the student shall sign this authorization form.

Students Consent:

HIV AIDS status, diagnosis, treatment – 14 years of age

Family Planning/Abortion – No age limit

Alcohol/Drug Treatment – 13 years of age

Mental Health Services – 13 years of age

SECTION III – AGENCY RECEIVING INFORMATION

Name/Agency	<p>This information disclosed to you is protected by state and federal law. You are prohibited from releasing it to an 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 medical or other information is not sufficient. See chapter 70.02RCW.</p> <p>Envelope shall be marked "CONFIDENTIAL"</p>
Address	
Name of School Psychologist	
Name of School Nurse	
Name of Other (Indicate position title)	