Authorization for Exchange of Health & Education Information
Walla Walla Public Schools

Student Name: _____ Date of Birth: _____ Grade: _____

Send information to: _____ **Attn**: _____

Address: _____

City, State, Zip: _____

Phone Number: _____ **Fax Number:** _____

Provider #1: _____

Address: _____

City, State, Zip: _____

Phone: _____Fax: _____

Provider #3: _____

Address: _____

City, State, Zip: _____

Phone: _____Fax: _____

Provider #2: _____

Address: _____

City, State, Zip: _____

Phone: _____Fax: _____

Provider #4: _____

Address: _____

City, State, Zip: _____

Phone: _____Fax: _____

I hereby authorize to exchange health and education information/records for the purpose listed below.

- ☐ Counseling Records
- ☐ Drug & Alcohol Records
- ☐ Health Records
- ☐ HIV/AIDS/Sexually Transmitted Diseases
- ☐ Mental Health Evaluation or Treatment Records
- ☐ Psychological Records
- ☐ Special Education Records
- ☐ Transcripts
- ☐ Other _____

DISCLOSED INFORMATION CONSISTS OF:

This information may be used for the following purpose(s): Educational evaluation and program planning / Health assessment and planning for health care services and treatment in school / Medical evaluation and treatment

This authorization expires at the end of the school year or on _____, (RCW 70.02.030) whichever is sooner. I understand that I may revoke this authorization at any time by submitting written notice of the withdrawal of my consent. I recognize the HIPAA Privacy Rule may not protect health records, once received by the school district, but may be protected by the Family Educational Rights and Privacy Act and other federal and state laws. I also understand that if I refuse to sign, such refusal will not interfere with my child's ability to obtain health care or educational services. I understand that the information obtained will be treated in a confidential manner and will be used by the MDT/IEP team to determine placement/programming decisions. I also understand that it is my right to request a copy of all student records and to contest any information I feel is incorrect.

_____ _____

Parent signature Date Student Signature Date

"Providing Health Care to Minors - RCW 26.28.010"

This information disclosed to you is protected by state and federal law. You are prohibited from releasing it to any 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 70.02 RCW

Copies: Parent or student*
Physician or other health care provider releasing the protected health information
School official requesting/receiving the protected health information

Envelope shall be marked **"CONFIDENTIAL"**

revised August 2006