



1113 Legion Way SE • Olympia, Washington 98501

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AUTHORIZATION FOR RELEASE/EXCHANGE OF RECORDS

Parent/Guardian Name: _____ Date: _____

Student Name: _____ Birthdate: _____

School: _____

I hereby authorize the release of records and confidential information:

From: _____	To: _____
Name of agency/person	Name of agency/person
_____	_____
Street Address	Street Address
_____	_____
City, State, Zip	City, State, Zip

Authorization is for mutual sharing of information and release of records by both parties to the other party.

Describe the records to be disclosed:

- Medical records/authorization is valid for 90 days.
- Mental health records/authorization is valid for 90 days.
- Special education records/authorization is valid for one year.
- Other _____

The reason for requesting release of record(s) is:

- determining special education eligibility,
- planning student's educational program,
- other _____

Please note that if the request is for health or medical information, the medical information received by the district is protected under FERPA privacy standards by a school district and not the Health Insurance Portability and Accountability Act (HIPAA).

This authorization is valid from ___/___/___ to ___/___/___.

Note: For release of medical records, the authorization can be no longer than 90 days after this authorization is signed.

I understand that my consent for the release of records is voluntary and I can withdraw my consent at anytime in writing. Should I withdraw my consent, it does not apply to information that has already been provided under the prior consent for release.

Parent/Guardian or Student Signature

Date