Authorization for Exchange of Medical Information

SECTION I—INFORMATION REQUESTED FROM

NAME/AGENCY	NAME OF PERSON DISCLOSING INFORMATION
ADDRESS	TITLE

Name of Student _____ Birth Date _____ Date _____

Specific nature of information to be disclosed:

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: _____

_____
Parent Signature Date

_____
Student Signature * Date

* 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	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.
ADDRESS	
_____ Name of School Psychologist	Envelope shall be marked **"CONFIDENTIAL"**
_____ Name of School Nurse	
_____ Name of Other (indicate position title)	