KELSO SCHOOL DISTRICT

Authorization for Release of Protected Health Information

Student: ________________________ Birth date: ___________________Grade:____________

School: __________________________ Student No:____________

PURPOSE OF AUTHORIZATION FOR THE RELEASE OF RECORDS: Information disclosed pursuant to this authorization will be used by the Kelso School District for identification, evaluation, placement of the student pursuant to the Individuals with Disabilities Education Act, 20 U.S.C. § 1400 *et seq.* ***and/or*** for the safe management of a student health, mental or substance abuse condition.

I hereby authorize the marked entity to disclose protected health information regarding the above named patient to representatives of the Kelso School District.

□ Child & Adolescent Clinic 971 11th Avenue Longview, WA 98632 360-577-1771 fax 360-423-9537	□ PeaceHealth Medical Group □ Team A □ Team B □ Team C 1615 Delaware Street Longview, WA 98632 360-414-2302 fax 360-414-2305	□ Pediatric Clinic 784 14th Avenue Longview, WA 98632 360-425-6111 fax 360-636-1297
□ Kaiser Permanente 1230 7th Avenue Longview, WA 98632 360-636-2400 fax 360-636-6242	□ Cowlitz Family Health Center 1057 12th Avenue Longview, WA 98632 360-636-3892 fax 360-414-1342	□ Castle Rock Pediatrics & Family Wellness Family Wellness Center 139 1st Avenue SW Castle Rock, WA 98611 360-274-2353 fax 360-274-2354

Or ☐ ____

____

Description of the information to be disclosed:
This release authorizes and requests disclosure of all medical, diagnostic, and treatment records in possession of the above-authorized health care provider regarding the above-named student, including but not limited to evaluations, testing, charts, protocols, raw data, observations, notes, and communications with the patient and patient's family.

By initialing, I also authorize release of the following information:

☐Chemical dependency (includes alcohol/drug treatment) ☐HIV/AIDS

☐Mental health information

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I understand that the information obtained by the Kelso School District will be treated in a confidential manner under the provisions of the Family Education Rights and Privacy Act (FERPA). FERPA prohibits disclosure of personally identifiable information without consent except in limited circumstances. Protected health information received by the District is protected under FERPA privacy standards and not the Health Insurance Portability and Accountability Act (HIPAA).

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I understand that the health care provider, who is being asked to provide medical health information to the school district, may not condition continuing treatment on whether or not I sign this authorization.

I understand that my consent for the release of records is voluntary, and I can withdraw my consent at any time in writing. However, I understand that any action taken in reliance on this authorization cannot be reversed, and my revocation will not affect those actions.

This authorization expires on _____________ (date) or upon occurrence of the following event that relates to me or the purpose of this authorization: _____________________________________. If this form does not contain an expiration date, it expires one year from the date this form was signed.

______________________________ __________ ______________________________ ________
Signature of Parent/Guardian/Adult Student Date Signature of Student over 13 years of age Date

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Street address City, State, Zip

AUTHORIZATION TO RELEASE EDUCATION RECORDS

Communication between District staff and your student's health care providers can help the District implement recommendations by the providers and incorporate the providers' expertise when identifying, evaluating, or recommending placement for a student. This authorization form allows District staff to discuss information contained in your student's education records with your student's health care provider.

I authorize the Kelso School District to release education records of the student named above to the above marked entity.

The reason for the release of records is:

To allow communication between the District and your student's health care providers.

The records to be released include:

Student academic, attendance and discipline records and
Student's special education status and information contained in special education files.

______________________________ ______________________________
Parent/ Guardian Signature Date

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