

EDMONDS SCHOOL DISTRICT
AUTHORIZATION FOR MUTUAL EXCHANGE
OF MEDICAL INFORMATION



I hereby authorize the mutual exchange of medical information regarding: (PLEASE PRINT)

Student: _____ Birthdate: ____/____/____ School: _____

This information to be exchanged between:

Agency/Individual/Physician: _____
Address: _____ City: _____ State: _____ Zip Code: _____ Phone: (____) _____

and

Edmonds School District
RETURN INFORMATION TO: _____

Describe the records to be disclosed: _____

Authorization: I understand that my child's records may contain information regarding the diagnosis or treatment of HIV/AIDS, sexually transmitted diseases, sexual assault treatment, drug and/or alcohol abuse, mental illness or psychiatric treatment.

Please initial the following information to be excluded from the records released:

- Drug/Alcohol abuse/treatment & diagnosis
HIV/AIDS diagnosis/treatment/testing
Sexual assault treatment records
Sexually Transmitted Disease
Mental Illness or Psychiatric diagnosis/treatment

PURPOSE: As a parent, guardian or student, you have the right to give permission or not give permission for the release of your child's records to or from other persons or agencies. This request provides you with the opportunity to approve or not approve such a request unless release of records is allowed under one of the exceptions under the rules implementing the Family Education Rights and Privacy Act, (FERPA), (for example, transfer of records from one school district to another).

Districts must comply with Health Insurance Portability and Accountability Act (HIPAA) requirements when requesting medical records on behalf of a student from a health provider. However, once the district receives those records, those records are considered educational records and should be handled consistent with the confidentiality requirements outlined under FERPA.

I understand that the information obtained will be treated in a confidential manner by the school district under the provisions of FERPA. FERPA prohibits disclosure of personally identifiable information without consent except in limited circumstances. 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 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 any time 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 (please print) Parent/Guardian Signature Date

Student Name (please print) Student Signature (SEE REVERSE)

White: Original sent with request
Yellow: If Special Education student, place in Student Services Legal File
If not Special Education student, place in Student Cumulative File

Age of Consent to Release Particular Records:

Ages when a minor's express written consent is needed to authorize exchange of his/her own particular medical records are as follows:*

<u>Health Care Information</u>	<u>Age of consent</u>
Human immunodeficiency virus (HIV)	14 years
Sexually transmitted diseases (STD)	14 years
Drug, alcohol abuse (outpatient)	13 years
Chemical dependency treatment (residential)	18 years
Mental health (outpatient)	13 years
Birth control	no age limit, student's consent is required
Abortion	no age limit, student's consent is required

*except as provided for in RCW 70.02.050