

Authorization for Exchange of Medical Information

Section I – INFORMATION REQUESTED FROM		
Name/Agency	Name of Person Disclosing Information	
Address	Title	
Student's Name	Birth Date	Date
Specific nature of information to be disclosed:		
Section II - AUTHORIZATION		
I Hereby authorize the release of medical information as described above to the individual 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		
Address		
Name of School Psychologist		
Name of School Nurse		
Name of Other (indicate position title)		

This information disclose 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.

Envelope shall be marked “CONFIDENTIAL”