San Juan Island School District
Friday Harbor, Washington 98250

AUTHORIZATION FOR EXCHANGE OF CONFIDENTIAL MEDICAL INFORMATION

Date _____ Student _____ DOB _____ Grade _____

Parent _____ Home phone _____ Work phone: Dad _____ Mom: _____

To Parents: We can help you better if we are able to work with health care providers and agencies that know you and your family. By signing this form, you are giving permission for the people and the agencies listed below to exchange information about your child for the purposes of educational planning and needs assessment.

I hereby authorize the exchange of confidential medical records regarding the above named student between the San Juan Island School District and:

Name of school district/agency/other	**Name of school district/agency/other**
Address	Address
Phone number FAX number	Phone number FAX number

I understand: my consent is required to release any of this information and will include all aspects of treatment unless limited by me in writing; I may give written cancellation of this release at any time, [this would not affect any information released before the cancellation]; and this information will be treated in a confidential manner and will not be transmitted to a third party without my permission.

Please note that the medical information received is protected under the Family Education Rights and Privacy Act [FERPA] privacy standards and not the Health Portability and Accountability Act [HIPAA].

Initial**	Information Requested (**Initial all that apply)	
	Medical records	
	Mental health services; including psychiatric information	[13 years of age; student consent required]
	Alcohol/drug information/treatment	[13 years of age; student consent required]
	Family planning/abortion	[student consent required]
	HIV/AIDS status, diagnosis, treatment	[14 years of age; student consent required]
	Other, as listed:	

Staff who have my permission to access this information [*name/position must be listed*]:

	School Nurse		Gen Ed Teacher
	Building Administrator		SLP/Audiologist
	School Psychologist		OT/PT
	School Counselor		Family Advocate
	Sp Ed Teacher		

PLEASE RETURN TO:
Name/Position
Address
Phone number FAX number

Consent expires in 90 days OR by this mutually upon date: _____ **I give consent for the information requested on this form to be FAXed to the school.**
Parent/Guardian/Adult student signature
Student signature, if required
Address

Copy: Compliance File or Health File Releasing Agency Parent
Rev: 6/04 kj