VANCOUVER SCHOOL DISTRICT NO. 37
Vancouver, Washington
Authorization and Consent for Release
and/or Exchange of Confidential Information

Student: _____ DOB: _____ Grade: _____

Student's Present School: _____

Requested by / Position: _____

I hereby authorize and consent to the release and/or exchange of the following confidential information relative to the above named student: (check all that apply)

☐ Academic	☐ Immunization	☐ Medical
☐ Current IEP	☐ Psychological	☐ Psychiatric
☐ Mental Health (Eval. /Treatment)	☐ Drug / Alcohol	☐ Audiological
☐ IEP Eligibility Statement	☐ Speech/Language	☐ Other: _____

INITIAL BELOW FOR RELEASE OF THE FOLLOWING INFORMATION:

_____ Substance Abuse (including drug and alcohol abuse)

_____ Mental Health Treatment

_____ Communicable Diseases (including sexually transmitted diseases)

_____ Genetic Testing

_____ HIV / AIDS information (including AIDS related testing)

I understand that this authorization may include substance abuse (including alcohol and drug abuse), mental health treatment, communicable disease (including sexually transmitted diseases), genetic testing information, and/or HIV information (including AIDS related testing) but only if I place my initials on the appropriate box above, specifically authorizing the release of such information. This information is protected by Federal confidentiality rules (42 CFR Part 2) and the Health Insurance Portability and Accountability Act of 1996 (HIPPA), 45 CFR, Parts 160 and 164. The Federal rules prohibit any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. The Federal rules restrict any use of the information to criminally investigate or prosecute an individual for alcohol or drug abuse.

This confidential information may be used by the person authorized below for educational services or other purposes as I may direct.

~ OVER ~

VANCOUVER SCHOOL DISTRICT NO. 37
Vancouver, Washington
Authorization and Consent for Release
and/or Exchange of Confidential Information

THIS CONFIDENTIAL INFORMATION IS TO BE RELEASED TO:

ATTN: _____

Phone: (____) _____ **/ Fax:** (____) _____

Address: _____

If applicable, this confidential information is to be exchanged with:

Name: _____
(Insert Name of Other District or Agency)

Address: _____

Phone/Fax: _____

Purpose: _____

I understand the information used or disclosed pursuant to this authorization may be subject to re-disclosure and may no longer be protected under federal law. However, I also understand that federal or state law may restrict re-disclosure of drug/alcohol diagnosis, treatment or referral information; mental health, H.I.V., communicable disease and genetic testing information. Confidentiality of information provided to the Vancouver School District is also protected by the federal Family Educational Rights and Privacy Act. (FERPA).

I understand that I do not have to sign this authorization in order to receive health care benefits (treatment, payment, enrollment or eligibility for benefits) from a health care provider or to receive education benefits.

I may revoke this authorization by writing to the Vancouver School District or by filling out a revocation form available from any school in the District. Any actions already taken by the Vancouver School District based upon this authorization prior to the revocation date cannot be undone.

This request is valid for the 2018-19 school year.

_____ _____
Signature of Parent/Guardian Date

_____ _____
Address Phone Number

_____ _____
Signature of Student (if applicable) Date