

VANCOUVER SCHOOL DISTRICT NO. 37
Vancouver, Washington

AUTHORIZATION AND CONSENT FOR RELEASE
AND/OR EXCHANGE OF CONFIDENTIAL INFORMATION

Student: _____ Birthdate: _____

Student's present school: _____

Requested by (name): _____ Position: _____

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

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

- | | |
|---------------------------------------------------------------|------------------------------------------|
| <input type="checkbox"/> Scholastic | <input type="checkbox"/> Psychological |
| <input type="checkbox"/> Medical | <input type="checkbox"/> Speech/Language |
| <input type="checkbox"/> Mental Health (Evaluation/Treatment) | <input type="checkbox"/> Audiological |
| <input type="checkbox"/> Drug/Alcohol | <input type="checkbox"/> Immunization |
| <input type="checkbox"/> Psychiatric | <input type="checkbox"/> Other _____ |

This confidential information is to be released to the Vancouver Public School District #37. If applicable, this confidential information is to be exchanged with:

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

For the purpose of: _____

This request is valid from the date below for a period of ninety (90) days.

I may revoke this authorization by writing to the Vancouver School District or filling out a revocation form available from any school in the district. If I did, it would not affect any actions already taken by the Vancouver School District based upon this authorization.

Once health care information is disclosed, the person or organization that receives it may re-disclose it in conformance with applicable laws. Confidentiality of information provided to the Vancouver School District is protected by the federal Family Educational Rights and Privacy Act.

Signature of Parent or Guardian

Address

Relationship

Phone number

Student Signature (when applicable)

Date

Original: Special Services Yellow: Receiving Agency Pink: Principal Gold: Parent

*** Confidential Records must be sent to:**

Vancouver School District
Special Services Records Request
PO Box 8937
Vancouver, WA 98668-8937