



Authorization For the Release of Records/Information

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 with 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).

Student's Name _____ Student's Date of Birth _____

Date _____ Parent/Guardian Name(s) _____

I hereby authorize the mutual exchange of confidential information and the release of records among and between the Arlington Public Schools and the person(s) or agency listed below:

From:	To:
_____	_____
<i>(Name of agency/person)</i>	<i>(Name of agency/person)</i>
_____	_____
<i>Street Address</i>	<i>Street Address</i>
_____	_____
<i>City, State, Zip</i>	<i>City, State, Zip</i>
_____	_____
<i>Phone (ie: 111-111-1111)</i>	<i>Phone (ie: 111-111-1111)</i>
_____	_____
<i>Fax</i>	<i>Fax</i>

Describe the records to be disclosed: (Check all that apply)

- | | |
|---|--|
| <input type="checkbox"/> Health/Medical Records | <input type="checkbox"/> Transcripts |
| <input type="checkbox"/> Psychological and Counseling Records | <input type="checkbox"/> Communication/exchange of information between agency and school |
| <input type="checkbox"/> Special Education Records | <input type="checkbox"/> Other _____ |

Release Requiring Specific Consent: Specific consent is required for release of the following information. Student consent is also required at the ages specified in parentheses below. Mental health records are protected under RCW 71.05.390 and Chapter 71.34 RCW. Drug and alcohol abuse and treatment records are protected under 42 C.F.R. § 2; information related to HIV/AIDS or sexually transmitted diseases is protected under RCW 70.24.105.

I specifically authorize the release of records relating to:

- | | |
|---|---|
| <input type="checkbox"/> Reproductive care (student consent always required) | <input type="checkbox"/> Mental health/illness (age 13 and older) |
| <input type="checkbox"/> Sexually transmitted diseases or HIV/AIDS (age 14 and older) | <input type="checkbox"/> Drug/Alcohol abuse (age 13 and older) |

The reason for disclosing the record(s) is:

- | | |
|---|--|
| <input type="checkbox"/> An evaluation or re-evaluation process | <input type="checkbox"/> An Individual Education Plan (IEP) is being developed |
| <input type="checkbox"/> A program review | <input type="checkbox"/> Other _____ |

I understand and acknowledge the following:

- * Released information will be treated in a confidential manner by the school district under the provisions of the Family Education Rights and Privacy Act (FERPA). FERPA prohibits disclosure of personally identifiable information without consent except in limited circumstances. 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 the Health Insurance Portability and Accountability Act (HIPAA).
- * The information released in response to this authorization may be re-disclosed to other parties.
- * I do not need to sign this form to assure treatment or payment. My treatment, payment, enrollment in any health plan, or eligibility for benefits is not conditioned on signing this authorization form.
- * My consent for the release of records is voluntary and I can withdraw my consent at any time, except to the extent that information has already been released in reliance upon this authorization. Revocation must be in writing.

This authorization is valid from _____ to _____

Note: If no dates are specified above, authorization will expire one year from date of signature below.

_____ Date _____ Date _____

Parent/Guardian Signature _____ Student Signature _____