

December 21, 2020

**Via Email:** [publicrecords@sno.wednet.edu](mailto:publicrecords@sno.wednet.edu)

Snohomish School District  
Public Records Officer  
1601 Avenue D  
Snohomish, WA 98290

Re: Student: [REDACTED]  
DOB: [REDACTED]

Dear Sir or Madam:

Our firm represents the family of [REDACTED] [REDACTED] (formerly known as [REDACTED]), a former student in the Snohomish School District. Pursuant to RCW 42.56 *et seq.*, *Lowy v. Peacehealth*, 174 Wash. 2d 769 (2012), and *Fellows v. Moynihan*, 175 Wash. 2d 641 (2012), please provide a copy a complete electronic copy of all records identifiable to [REDACTED], including but not limited to:

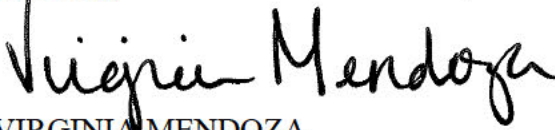
1. All emails, communications, letters, investigation reports and investigation files, videos, transcripts, and other documents referencing [REDACTED] (formerly [REDACTED]);
2. Assessment plans;
3. Attendance records;
4. All records of data collection, charts, logs, of any kind;
5. Disciplinary records;
6. All psychological evaluations, if any;
7. All grade reports, report cards, and progress reports;
8. All transcripts;
9. All IEP plans;
10. All regular and special education records;
11. All requests/referrals for evaluations;
12. All test scores;

13. All school nurse notes and records of any kind;
14. All therapist's logs, if any;
15. Notes of telephone calls; and
16. Any other record that is a part of his file.

Enclosed please find a release signed by [REDACTED] mother, [REDACTED], permitting the disclosure of information regarding [REDACTED] otherwise protected by FERPA. Please note Ms. [REDACTED] adopted [REDACTED] on August 24, 2018. The Decree of Adoption is also enclosed for your records.

If there is a cost to produce electronic files please advise of the total cost before production, at [mendoza@sgb-law.com](mailto:mendoza@sgb-law.com) or at (206) 233-1258. Thank you for your attention to the foregoing.

Sincerely,



VIRGINIA MENDOZA  
Legal Assistant to Page B. Ulrey

Enclosures

**MEDICAL AUTHORIZATION AND REQUEST FOR CONFIDENTIAL TREATMENT  
OF MEDICAL INFORMATION CONCERNING MINOR PATIENT**

TO: Snohomish School District

**AUTHORIZED ATTORNEY:**  
Schroeter, Goldmark & Bender  
810 Third Avenue, Suite 500  
Seattle, WA 98104

PATIENT/MINOR NAME: [REDACTED]

DATE OF BIRTH: [REDACTED]

1. **AUTHORIZATION FOR RECORDS AND REPORTS.** You are hereby authorized and directed to permit the examination, and the copying or reproduction in any manner, whether mechanical, photographic, or otherwise, by the authorized attorney or such other person as the authorized attorney may authorize, for the purpose of legal representation, of all or any portions desired by him/her of the following:

- A. The minor patient's hospital records, X-rays, X-ray readings and reports, laboratory records and reports, all tests of any type, character and reports thereof, statements of charges, and any and all of the minor patient's records pertaining to hospitalization, history, condition, treatment, diagnosis, prognosis, etiology or expense;
- B. The minor patient's medical records, including patient's record cards, X-rays, X-ray readings and reports, laboratory records and reports, all tests of any type and character and reports thereof, statements of charges, and any and all of the minor patient's records pertaining to medical care, history, condition, treatment, diagnosis, prognosis, etiology or expense.
- C. Pharmaceutical or prescription records, including statements of charges or expense.
- D. The minor patient's records or information related to insurance, including insurance policies, insurance coverage, payment of premiums or benefits, claim file(s) and any correspondence between you and the minor patient or relating to the patient.
- E. Any information relating to sexually transmitted diseases, mental illness, psychiatric treatment, HIV/AIDS, and/or drug/alcohol abuse, the confidentiality of which is protected by federal law, including 42 CFR, Part 2 and RCW 70.24 is excluded unless listed otherwise below.

**I UNDERSTAND THAT THIS CONSENT IS TO INCLUDE DISCLOSURE OF: (PLEASE INITIAL EACH)**

[REDACTED] Drug/Alcohol Abuse Records  
[REDACTED] HIV/AIDS Information

[REDACTED] Sexually Transmitted Disease Information  
[REDACTED] Mental Illness or Psychiatric Records

You are further authorized and directed to furnish oral and written reports to the authorized attorney or his/her delegate, as requested by said attorney on any of the foregoing matters.

2. **REQUEST FOR CONFIDENTIALITY AND REVOCATION OF PREVIOUS AUTHORIZATIONS.** By reason of the fact that such information that you have acquired as the minor patient's physician or surgeon is confidential and protected under federal and state confidentiality regulations, you are also requested to treat such information as confidential and requested not to furnish any of such information in any form to anyone, without written authorization from me. I hereby revoke any previously-dated medical waiver or authorization. **Caution: Please alert your staff to the restrictions on the release of information of any nature whatsoever regarding me to unauthorized persons.**

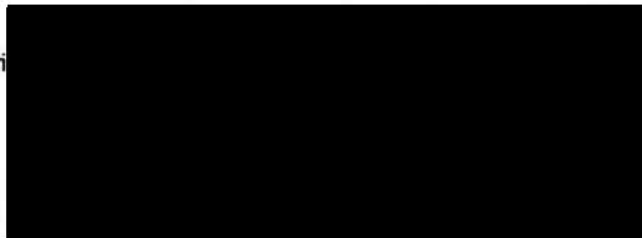
**MY RIGHTS:** I understand I am not required to sign this authorization in order to obtain health care benefits (treatment, payment or enrollment). I may revoke this authorization at any time prior to its expiration date by notifying the providing organization in writing, but I understand that once the health information I have authorized to be disclosed reaches the noted recipient, that person or organization may re-disclose it, at which time it may no longer be protected under Privacy laws. I may see and copy the information described on this form if I ask for it.

3. **AUTHORIZATION FOR PHOTOGRAPHS.** I also permit the authorized attorney or his/her delegate to photograph my person while I am present in any hospital.

4. **DURATION OF AUTHORIZATION.** This authorization shall be valid for a period of 90 days or until advised in writing by me of its revocation before 90 days from date hereof.

5. **EFFECT OF A COPY.** A photostatic copy of this authori

December 21, 2020  
DATE



TO: ANY INDIVIDUAL, FIRM, CORPORATION, DOCTOR, HOSPITAL AND  
GOVERNMENTAL AGENCY OF ANY LOCAL, STATE OR NATIONAL  
GOVERNMENT

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RE: 

I, the undersigned, do hereby authorize and consent to the release of the following information pertaining to me, including, but not limited to, records, notes, histories, reports, files, summaries of files, statements, tape recordings, financial records, X-rays, photographs and other written or recorded information:

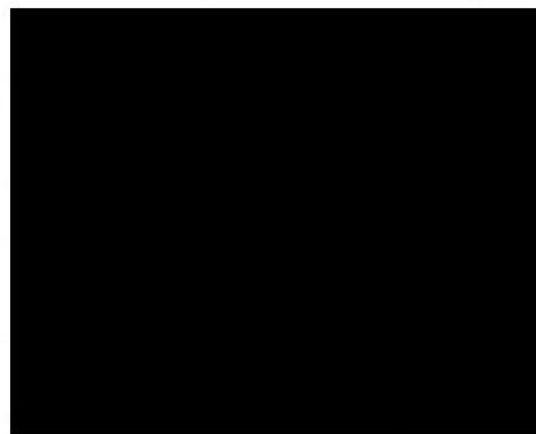
- A. Medical records
- B. Military service records
- C. Income and property tax records
- D. Employment records
- E. Unemployment records
- F. Vocational records
- G. Vocational training or rehabilitation records
- H. Attorney records
- I. Records of any governmental agency concerning or in any way related to local, state or federal employment, disability or vocational education or training benefits or programs of any nature, including, but not limited to, social security, employment security, veterans, workers compensation and vocational education benefits.
- J. School records
- K. Police/Fire Department records

Such information, etc., is to be released to Virginia Mendoza of Schroeter, Goldmark & Bender, 500 Central Building, 810 Third Avenue, Seattle, Washington 98104.

**By reason of the fact that such information that you have acquired is confidential to me, you are also requested to treat such information as confidential, and are requested not to furnish any of such information in any form to anyone, without written authorization from me. I hereby revoke any previously dated authorization or release.**

A photostatic copy of this authorization shall be considered as effective and valid as the original.

DATED. December 21, 2020



STATE OF WASHINGTON  
DEPARTMENT OF HEALTH



CERTIFICATE OF LIVE BIRTH



FIRST AND MIDDLE NAME(S):

LAST NAME(S):

DATE OF BIRTH:

PLACE OF BIRTH (COUNTRY):

MOTHER'S NAME PRIOR TO FIRST MARRIAGE:

MOTHER'S PLACE OF BIRTH:

WASHINGTON

FATHER'S NAME:

FATHER'S PLACE OF BIRTH:

WASHINGTON

SEX:

MALE

MOTHER'S DATE OF BIRTH:

FATHER'S DATE OF BIRTH:

FEE NUMBER:

4609051707

NOT VALID IF PHOTOCOPIED OR ALTERED

DOH 402-132 (4/18)

COUNTY CLERK OFFICE  
FILED

AUG 24 2018

IN THE SUPERIOR COURT OF WASHINGTON  
IN AND FOR THE COUNTY OF SAN JUAN

In re the Adoption of:

No. 18-5-05003-28

DECREE OF ADOPTION

a person under the age of eighteen years.

I. ADOPTION SUMMARY

Prior Name of Child:

New Name of Child:

Date of Birth:

Place of Birth:

Petitioners:

and wife

, husband

II. ORDER

THIS MATTER having come on for regular hearing this date, and the Court having entered its Findings of Facts and Conclusions of Law,

NOW THEREFORE IT IS ORDERED that the petition of [REDACTED] and [REDACTED], husband and wife, to adopt the above-named child is GRANTED.

IT IS FURTHER ORDERED that the name of the child is changed to [REDACTED], and that the Washington State Department of Social and Health Services, Office of Vital Records, shall issue a birth certificate for the child showing him as the child of [REDACTED] and [REDACTED], husband and wife.

IT IS FURTHER ORDERED that the Clerk of the Court shall issue two certified copies of this Decree, one for the use and benefit of the Washington State Department of Social and Health Services, Office of Vital Records, and one to be delivered to Petitioners [REDACTED] and [REDACTED], husband and wife.

DECREE OF ADOPTION, 1 of 2.

BRANDLI LAW PLLC  
1 FRONT ST. N, STE. D-2 • PO BOX 850  
FRIDAY HARBOR, WA 98250-0850  
(360) 378-5544 • (360) 230-4637 (FAX)

1 IT IS FURTHER ORDERED that the records of the Washington State Department  
2 of Social and Health Services, Office of Vital Records, and the files and records of this  
3 case, shall be kept confidential and shall be disclosed only upon order of this Court, for  
4 good cause shown.  
5

6 Dated: 8/24/2018 ✓

[Signature]  
7 Judge

8 Presented by:

9  
10 BRANDLI LAW PLLC

11  
12 By: [Signature]

13 Stephen A. Brandli, WSBA #38201  
14 Attorney for Petitioners  
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DECREE OF ADOPTION, 2 of 2.

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STATE OF WASHINGTON  
COUNTY OF SAN JUAN

I, LISA A. HENDERSON, Clerk of the above entitled County, do hereby certify that the foregoing instrument is a true and exact copy of the original now on file in my office.

In witness whereof, I hereunto set my hand and the seal of said Court this 24 day of Aug, 20 18

LISA A. HENDERSON, COUNTY CLERK

By: Lisa A. Henderson  
Deputy Clerk