DOC ID 026

SNOHOMISH HIGH SCHOOL
ATTN: Custodian of Records
1316 5TH STREET
SNOHOMISH, WA 98290

MRC

6/17/2021

CUSTODIAN OF RECORDS:
SNOHOMISH HIGH SCHOOL
Attention: Custodian of Records
1316 5TH STREET
SNOHOMISH, WA 98290

Request For: **Academic Records**
RE: [redacted]
REQUEST NUMBER: **PCBOE-P4-10001801671**

Send all records and correspondence by 7/1/2021 to:

MRC
10550 Richmond Avenue, Suite 310
Houston, TX 77042
866-933-0137 Fax
imageprocessing01@mrchouston.com Email

Dear Sir or Madam:

You are hereby presented with a signed authorization necessary for the release of a complete and unabridged copy of all records within your custody pertaining to the above individual as described below:

Any and all records including, but not limited to, academic, attendance, scholastic, extracurricular, counseling and/or disciplinary records, as well as transcripts and nurses' notes.

If you possess records, please complete SECTION I: CERTIFICATION OF CUSTODIAN OF RECORDS and return it with a complete copy of any and all records you have pertaining to Wahl, Ashley.

If you do not possess records, please complete SECTION II: CERTIFICATION OF NO RECORDS**,** indicating your retention period and reason why records cannot be produced.

MRC will expect all charges to be reasonable and customary and in compliance with your state statutes. Please include your Federal Tax ID number and the request number on all invoices.

Should your fee for copying records exceed $500.00 please contact our office for approval prior to copying records.

THIS INDIVIDUAL IS INVOLVED IN A CIVIL LITIGATION
Please retain any and all records indefinitely.

CERTIFICATION FOR ACADEMIC RECORDS

CUSTODIAN OF RECORDS:
SNOHOMISH HIGH SCHOOL
1316 5TH STREET
SNOHOMISH, WA 98290

Request For: Academic Records
RE: [redacted]
MRC Request Number: PCBOE-P4-10001801671

Request for:
Any and all records including, but not limited to, academic, attendance, scholastic, extracurricular, counseling and/or disciplinary records, as well as transcripts and nurses' notes.

SECTION I: CERTIFICATION OF CUSTODIAN OF RECORDS

I the undersigned, being the authorized custodian of records or other qualified witness, and having the authority to certify the attached records proclaim the following:

The attached records (1): were made at or near the time the act, event, condition, opinion or diagnosis by a person with knowledge of the matters reflected in the records; (2): were kept in the course of regularly conducted activity; (3): Were created as part of the regular practice of the provider; and (4): are the complete and unabridged copies of records maintained by this facility with regards to the above-named plaintiff.

I DECLARE UNDER PENALTY OF PERJURY THAT THE FOREGOING IS TRUE AND CORRECT

a. Signature: _____ b. Print Name: _____

c. Executed on (date):_____

SECTION II: CERTIFICATION OF NO RECORDS

A thorough search of our files, carried out under my directions revealed no documents, records or other materials called for in the request or authorization.

Please check all that are applicable to your search for records

1. [ ] A thorough search of the subject's SS#, Date of Birth and all aka's was done and no such records were found, and to the best of my knowledge these records do not exist in storage.
2. [ ] These records have been destroyed. Our retention policy is _____ years.
3. [ ] These records are in the possession of _____.

I DECLARE UNDER PENALTY OF PERJURY THAT THE FOREGOING IS TRUE AND CORRECT

a. Signature: _____ b. Print Name: _____

c. Executed on (date):_____

PLEASE RETURN THIS PAGE

10550 Richmond | Suite 310 | Houston, TX 77042 | T. 888.868.6769 | F. 866.933.0137 | mrchouston.com

HIPAA COMPLIANT AUTHORIZATION FORM
FOR THE RELEASE OF EDUCATION RECORDS
PURSUANT TO 45 CFR 164.508

To: **Snohomish High School**
1316 5th Street
Snohomish, WA 98290

For the purpose of adjudicating a lawsuit.

Name: [redacted]
Date of Birth:
Social Security Number:

I authorize disclosure of all protected medical or other confidential information for the purpose of review and evaluation in connection with a legal claim. I expressly request that all covered entities HIPAA identified above disclose full and complete protected medical information spanning the time period of July 2, 1990 to the present including, but not limited to, the following:

- **All attendance records, teachers' notes and reports and disciplinary records.**
- **All guidance counseling records, psychological records, drug and/or alcohol counseling records.**
- **All medical/school nurse/infirmary records.**
- **All medical records, including inpatient, outpatient and emergency room treatment, all clinical charts, reports, documents, correspondence, test results, statements questionnaires/histories, office and doctor's handwritten notes, and records received by other physicians.**
- **All autopsy, laboratory, histology, cytology, pathology, radiology, CT Scan, MRI, echocardiogram and cardiac catheterization reports.**
- **All radiology films, mammograms, myelograms, CR scans, photographs, bone scans, pathology/cytology/histology/autopsy/immunohistochemistry specimens, cardiac catheterization videos/CDs/films/reels, and echocardiogram videos.**
- **All pharmacy/prescription records include NDC numbers and drug information handouts/monographs.**
- **All billing records including all statements, itemized bills, and insurance records.**
- **Any of the above records in storage.**

Information about alcohol/substance abuse and HIV/AIDS and other infection diseases may be disclosed as follows: (check all that apply)

	Yes, disclose HIV/AIDS and other infection diseases information
	Yes, disclose alcohol/substance abuse information

X	No, do NOT disclose HIV/AIDS and other infection diseases information
X	No, do NOT disclose alcohol/substance abuse information

I authorize you to release the protected health information to the following representative of defendants in the above-entitled matter who have agreed to pay reasonable charges made by you to supply copies of records:

Medical Research Consultants (MRC)
10550 Richmond, Suite #310
Houston, TX 77042

I acknowledge the potential for information disclosed pursuant to this authorization to be subject to re-disclosure by the recipient and no longer be protected under 45 CFR 164.508.

I intend that this authorization shall be continuing in nature. If information responsive to this authorization is created, learned or discovered at any time in the future, either by you or another party, you must produce such information to the requestor at that time.

I understand that the records will be reviewed by employees of Perkins Coie LLP, The Boeing Company, Gordon Rees Scully Mansukhani, LLP, Newco, Inc., d/b/a Cascade Distribution Company, expert witnesses, court personnel or any other persons or entities as required for the investigation of my claim against The Boeing Company and/or Newco, Inc., d/b/a Cascade Distribution Company or in connection with any court or legal proceedings that I have brought against The Boeing Company and/or Newco, Inc., d/b/a Cascade Distribution Company.

I understand that the information disclosed in the records may be re-disclosed, as necessary, by the recipients of the records to other attorneys retained by The Boeing Company and/or Newco, Inc., d/b/a Cascade Distribution Company or to attorneys retained by me or to expert witnesses, court personnel or any other persons or entities as required for the investigation of my claim against The Boeing Company and/or Newco, Inc., d/b/a Cascade Distribution Company or in connection with any court or legal proceedings that I have brought against The Boeing Company and/or Newco, Inc., d/b/a Cascade Distribution Company.

I understand I have the right to revoke this authorization at any time. I understand if I revoke this authorization I must do so by giving written notice of my revocation to the information management department. I understand the revocation will not apply to information that has already been released in response to this authorization. I understand the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire at the conclusion of litigation and/or resolution of claim.

I understand that authorizing the disclosure of this information is voluntary. I may refuse to sign this authorization. I need not sign this form in order to assure treatment, payment, enrollment, or eligibility for benefits. I understand I may inspect or copy the information to be used or disclosed, as provided in CFR 164.524. I understand any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact above named provider's HIM director, privacy officer, or risk management officer.

I understand the potential for information disclosed pursuant to this authorization to be subject to redisclosure by a recipient and not protected under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA").

I understand I have the right to receive a copy of this authorization. I also understand and agree that a copy or facsimile of my signature will be counted as valid as the original.

[redacted] 5/10/24

Signature of Individual or Legal Representative — Date

[redacted] (Printed Name)

If Signed by Legal Representative, Relationship to Patient — Signature of Attorney or Witness