DOC ID 088

Transmission Report

Date/Time	04-09-2019	01:16:56 p.m.	Transmit Header Text
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SNOHOMISH SCHOOL DISTRICT

Snohomish School District

1601 Ave D
Snohomish WA 98290

PURPOSE: As a parent, guardian or student, you have the right to 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 the Family Education Rights and Privacy Act, FERPA, or its implementing regulations (for example, transfer of records from one school district to another)

AUTHORIZATION FOR RELEASE/EXCHANGE PSYCHOLOGICAL AND MEDICAL RECORDS

Student Name: [redacted] Date: 3/14/19

Student Birthdate: [redacted] Parent(s): [redacted]

I hereby authorize the release of records:

From: Providence Autism Center (Name of agency/school/person)
900 Pacific Ave (Street Address)
Everett WA 98201 (City, State, Zip)
Phone: 425-258-7077

To: Cheri Peach/Snohomish School Distric (Name of agency/school/person)
1601 Ave D (Address)
Snohomish, WA 98290 (City, State, Zip)
Phone: 360-563-7321
FAX - 360-563-7303

Person making request: Elizabeth Miller

Describe the records to be disclosed:

Health Records ☒ Psychological and Counseling Records ☒ Special Education Records ☒
Transcripts ☐ Communication/exchange of information between and agency and school ☒
Educational Records ☐ Other Specify: _____

Release Requiring Specific Consent: Specific consent is required for release of the following information. Minor signature is also required at the ages specified below. Medical records are regulated by RCW 70.02. Mental health services for minors are regulated under RCW Chapter 71.34; Drug and alcohol abuse and treatment records are protected under 42 C.F.R § 2; Information related to HIV/AIDS or sexually transmitted disease diagnosis and treatment of minors is provided under RCW 70.24.110.

I specifically authorized the release of records relating to:

Reproductive Care ☐ Mental Health/Illness (age 13 and older) ☐ Drug/Alcohol Abuse (age 13 and older) Sexually Transmitted Diseases or HIV/AIDS (age 14 and older) ☐

The reason for disclosing the record(s) is:

An Evaluation or Reevaluation Process ☒ A program review ☐ An IEP is being developed ☒
Support Therapeutic Goals ☐ Other Specify: _____

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.
- 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 3/14/19 to 6/30/19

[redacted] 3-14-19
Date

Student Signature Date

3231F2
8/2018

Total Pages Scanned : 1 Total Pages Confirmed : 1

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Abbreviations:

HS: Host send	PL: Polled local	MP: Mailbox print	CP: Completed	TS: Terminated by system
HR: Host receive	PR: Polled remote	RP: Report	FA: Fail	G3: Group 3
WS: Waiting send	MS: Mailbox save	FF: Fax Forward	TU: Terminated by user	EC: Error Correct

AUTHORIZATION TO EXCHANGE PATIENT HEALTH INFORMATION WITH SCHOOL

Patient Name: [redacted] **Seattle Children's Medical Record #** (if known) _____ **Date of Birth** [redacted]

I authorize Seattle Children's Hospital to (check all that apply):

☐ **Obtain information from** ☒ **Release information to** ☐ **Oral exchange only**

School & Contact Person (if known): Snohomish School District Attn: Cheri Peach

Address 1601 Avenue D

City, State, Zip Snohomish WA 98290

Phone # (360) 563-7321 Fax # (360) 563-7303

Information to be Released to School/Contact:

Dates of service for records release: from 5/30/16 **to** Present

- ☒ Outpatient Clinic Notes
- ☐ Discharge Summary
- ☐ Other: _____
- ☐ Occupational Therapy Reports
- ☐ Speech and Language Reports
- ☐ Other: _____
- ☐ Physical Therapy Reports
- ☐ Nutrition Reports
- ☐ _____

Information to be Obtained from School/Contact:

Dates of service for records requested: from 5/30/16 **to** Present

- ☐ Psychological Testing/Assessment
- ☐ Pupil Health Records
- ☐ Education Testing/Records
- ☐ Individual Education Plan (IEP) Special Services Record
- ☐ Early Intervention Services Plan
- ☐ Current/Past Medications
- ☒ Medical Treatment Records (including Clinic Notes)
- ☐ Physical Therapy Reports
- ☐ Occupational Therapy Reports
- ☐ Speech/Language Reports
- ☐ Audiology Reports
- ☒ Other Neurodevelopmental Clinic

If obtaining records from a school, requested records to be sent to:

☐ Seattle Children's Hospital, Attn: _____ Mailstop _____

P.O. Box 5371, Seattle, WA 98145, Phone _____ Fax _____

Seattle Children's: ☐ Bellevue Clinic ☐ Everett Clinic ☐ Federal Way Clinic ☐ Olympia Clinic ☐ Tri-Cities Clinic

☐ Bellevue at Overlake Medical Tower ☐ South Sound Cardiology ☐ Pediatric Cardiology of Alaska ☐ Odessa Brown

☐ Other _____ ☐ Wenatchee Clinic *See reverse side for clinic addresses*

I understand that:

- Authorizing the disclosure of this health information is voluntary. I do not need to sign this form in order to assure treatment or payment.
- I can cancel this authorization at any time by writing to the Health Information Management Department. I understand that once the information has been released according to the terms of this authorization, the information cannot be recalled.
- Any disclosure of information carries with it the potential for further release or distribution by the recipient that may not be protected by confidentiality laws.

This authorization will expire one year from the date signed below unless another date or event is entered here _____.

Exception: If patient information is to be released to an employer or financial institution, this authorization is valid for only 90 days from date signed.

[redacted] [redacted]

Signature of Patient/Legal Representative / Printed Name

Mother [redacted] 3-14-19 12:55

Relationship to Patient / Phone Number / Date Signed / Time Signed

Release Requiring Specific Consent- I specifically authorize Children's to release health information checked below:

☐ Mental Health/Illness ☐ Alcohol/Drug Abuse ☐ Sexually Transmitted Diseases (incl. HIV/AIDS) ☐ Reproductive Care

_____ _____ _____ _____

Signature of Patient/Legal Representative / Printed Name / Date / Time

Minors - A minor patient's signature is required in order to release the following information: 1) conditions relating to reproductive care including, but not limited to, birth control and pregnancy-related services and sexually transmitted diseases, including HIV/AIDS, (age 14 and older) and 2) substance abuse diagnosis or treatment and mental health conditions (age 13 and older).

STAFF

Clinic/Unit:

For Obtain requests: mail or fax authorization, then place copy in chart. If chart is unavailable, send copy to HIM Filing, OC.6.820.

For Release requests: Do you need HIM Department to send these records? Yes ☐ No ☐

If YES, send authorization to HIM, OC.6.820 If NO, place copy in chart, or send copy to HIM Filing, OC.6.820.

Name: _____ Clinic/Unit: _____ Ext: _____

Please Print

PLEASE SEE REVERSE SIDE FOR MORE INFORMATION

Seattle Children's®
HOSPITAL · RESEARCH · FOUNDATION

52360

AUTHORIZATION TO EXCHANGE PATIENT HEALTH INFORMATION WITH SCHOOL

White - Chart Yellow - Legal Representative / Patient Pink - Organization / Individual

Guidelines for completing *Authorization to Exchange Patient Health Information with School form*

Purpose: To ask a school to share information about your child with a Children's health care provider, to have a Children's health care provider share information with someone at your child's school, or both.

Instructions to Staff:

- Check for completeness/legibility of key information:
  - Patient information
  - School contact's name and address
  - Clear indication of information being requested (both release and obtain portions, if appropriate)
  - Complete information about Children's recipient (clinic or provider)
  - Legal representative/patient's signature and contact information
- Complete the staff box, including your signature and department name and extension (to be contacted in case of a question)

What to do with the form:

- For Obtain requests: Mail or fax form to the school contact and
  - Place copy in chart, or
  - If chart unavailable, send to HIM filing (OC.6.820)
- For release requests, clinic should provide information, if possible
  - Place copy in chart, or
  - If chart unavailable, send to HIM filing (OC.6.820)
- If you need HIM to send these records, please send to HIM (OC.6.820) with "yes" box in staff section checked

Guidelines for Families:

Completing the form:

- Please make sure to complete all relevant sections of this form, including:
  - Patient information
  - Detailed name and address of school contact
  - Signature of legal representative/patient, and contact information

Where to take or send it:

- If you complete this form at Children's, give it to a clinic or inpatient unit staff member to send to the Health Information department
- If you are completing this form at home, mail or fax the completed form to the Seattle Children's Health Information department at: PO Box 5371 M/S OC.6.820 Seattle, WA 98145

Where to call with questions:

- Complete this form in clinic with staff member assistance, or
- Call the Health Information department (206) 987-2173

Additional Information

CONSENT OF MINOR

A minor patient's signature is required in order to release the following Information: 1) conditions relating to reproductive care including, but not limited to, birth control and pregnancy-related services and sexually transmitted diseases, including HIV/AIDS, (age 14 and older) and 2) substance abuse diagnosis or treatment and mental health conditions, (age 13 and older).

FEE FOR COPYING MEDICAL RECORDS

There may be a fee for copying the medical records. Please ask the Release of Information personnel for information about the fee schedule. There will be a charge for copying the entire record.

PROHIBITION ON REDISCLOSURE OF HEALTH INFORMATION

Federal and state laws prohibit redisclosure of information concerning drugs and alcohol abuse treatment, sexually transmitted disease information or mental health information without the specific written consent of the person to whom the information pertains, or as otherwise permitted by law. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

Clinic Addresses

Odessa Brown Children's Clinic, 2101 E. Yesler Way, Seattle, WA 98122, 206-987-7210, Fax 206-987-7206
Pediatric Cardiology of Alaska, 3841 Piper St. Suite T 345, Anchorage, AK 99508, 907-339-1945, Fax 907-339-1994
Seattle Children's Bellevue at Overlake Medical Tower, 1135 - 116th Ave NE, Suite 400, Bellevue, WA 98004, 425-454-4644, Fax 425-451-0214
Seattle Children's Bellevue Clinic, M/S CB-21, PO Box 5371, Seattle, WA 98145-5005, 425-454-4644, Fax 206-884-9363
Seattle Children's Everett Clinic, 900 Pacific Ave, Suite 100, Everett, WA 98201, 425-304-6080, Fax 425-304-6085
Seattle Children's Federal Way Clinic, 34503 9th Ave S., Suite 300, Federal Way, WA 98003, 253-838-5878, Fax 253-838-1962
Seattle Children's Olympia Clinic, 615 Lilly Road NE, Suite 140, Olympia, WA 98506, 360-459-5009, Fax 360-459-8785
Seattle Children's Tri-Cities Clinic, 969 Stevens, Suite 1B, Richland, WA 99352, 509-946-0976, Fax 509-946-0983
Seattle Children's Wenatchee Clinic, 526 N. Chelan Ave, Suite B, Wenatchee, WA 98801, 509-662-9266, Fax 509-662-9284
South Sound Cardiology, 1901 South Cedar Street, Suite 103, Tacoma, WA 98405, 253-272-1812, Fax 253-682-1455