DOC ID 105

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 [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) **To:** Cheri Peach / Snohomish School Distri (Name of agency/school/person)

900 Pacific Ave (Street Address) 1601 Ave D (Address)

Everett WA 98201 (City, State, Zip) Snohomish, WA 98290 (City, State, Zip)

Phone: 425-258-7097 Phone: 360-563-7321
FAX - 360-563-7303

Person making request: [redacted]

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.

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: _____

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

arent/Guardian Signature Date

udent Signature Date

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8/2019