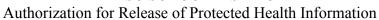
KELSO SCHOOL DISTRICT





Student:	Birth date:	Grade:
School:	Student #:	
School Contact Name: School Counselor Name	Contact #: School Coun	selor Number
authorization will be used by the Kelso School the student pursuant to the Individuals with Disamd/or for the safe management of a student her	District for identification, evalu abilities Education Act, 20 U.S.	ation, placement of C. § 1400 et seq.
I hereby authorize the marked entity to disclose p patient to representatives of the Kelso School Distric	protected health information regard. Entity not listed below or parent(s) of students.	arding the above named at over 13 as approved by student.
\underline{Or} choose from the following:		
Description of the information to be disclosed: This release authorizes and requests disclosure of possession of the above-authorized health care protection to evaluations, testing, charts, protocout with the patient and patient's family.	rovider regarding the above-nar	ned student, including bu
I also authorize release of the following informat: Please mark all that apply Chemical dependency (includes alcohol		

I understand that the information obtained by the Kelso School District will be treated in a confidential manner 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. Protected health information received by the District is protected under FERPA privacy standards and not the Health Insurance Portability and Accountability Act (HIPAA).

I understand that the health care provider, who is being asked to provide medical health information to the school district, may not condition continuing treatment on whether or not I sign this authorization. I understand that my consent for the release of records is voluntary, and I can withdraw my consent at any time by providing written notice to the health care entity identified above. However, I understand that any action taken in reliance on this authorization cannot be reversed, and my revocation will not affect those actions. If authorization is over one year (date) or upon occurrence of the following event that relates to This authorization expires on me or the purpose of this authorization: . If this form does not contain an expiration date, it expires one year from the date this form was signed. Student 13 & over sign & date here Signature of Student over 13 years of age Signature of Parent/Guardian/Adult Student Date under 13. Street address City, State, Zip If medical records are being requested, please FAX or mail to: Kelso Public Schools ATT: 601 Crawford Kelso, WA 98626 FAX: (360) 501-1965 AUTHORIZATION TO RELEASE EDUCATION RECORDS Communication between District staff and your student's health care providers can help the District implement recommendations by the providers and incorporate the providers' expertise when identifying, evaluating, or recommending placement for a student. This authorization form allows District staff to discuss information contained in your student's education records with your student's health care provider. I authorize the Kelso School District to release education records of the student named above to the above marked entity. The reason for the release of records is: To allow communication between the District and your student's health care providers. The records to be released include: Student academic, attendance and discipline records and Student's special education status and information contained in special education files. sign only Parent/ Guardian Signature Date

school records are requested.

Parent

when student

Parent

sign &

date for

student

Rev. 5/12/23