KELSO SCHOOL DISTRICT
Authorization for Release of Protected Health Information

Student: _____ Birth date: _____ Grade:____

School: _____ Student #: _____

School Contact Name:_____ Contact #: _____
School Counselor Name School Counselor Number

PURPOSE OF AUTHORIZATION FOR THE RELEASE OF RECORDS: Information disclosed pursuant to this authorization will be used by the Kelso School District for identification, evaluation, placement of the student pursuant to the Individuals with Disabilities Education Act, 20 U.S.C. § 1400 *et seq.* ***and/or*** for the safe management of a student health, mental or substance abuse condition.

I hereby authorize the marked entity to disclose protected health information regarding the above named patient to representatives of the Kelso School District. Entity not listed below or parent(s) of student over 13 as approved by student.

_____

_____

_____

Or choose from the following:

SELECT from dropdown options	SELECT from dropdown options
SELECT from dropdown options	SELECT from dropdown options
SELECT from dropdown options	SELECT from dropdown options

Description of the information to be disclosed:
This release authorizes and requests disclosure of all medical, diagnostic, and treatment records in possession of the above-authorized health care provider regarding the above-named student, including but not limited to evaluations, testing, charts, protocols, raw data, observations, notes, and communications with the patient and patient's family.

I also authorize release of the following information:
Please mark all that apply

☐Chemical dependency (includes alcohol/drug treatment) ☐HIV/AIDS

☐Mental health information ☐Primary Care

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).

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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

This authorization expires on _____ (date) or upon occurrence of the following event that relates to 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.

Parent sign & date for student under 13.

Student 13 & over sign & date here

_____ _____ _____ _____

Signature of Parent/Guardian/Adult Student Date Signature of Student over 13 years of age Date

_____

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.

Parent sign only when student school records are requested.

_____ _____

Parent/ Guardian Signature Date

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