Wahkiakum School Dist. #200

265 S. 3rd. St., Cathlamet, WA 98612

AUTHORIZATION FOR RELEASE OF RECORDS

Identifying Information

Student Name:_____ Date:_____

Student DOB:_____ School District: Wahkiakum School District

I Hereby authorize the release of records:

From: To:

Name of Agency/Person:	Name of Agency/Person: Wahkiakum School Dist.
Street Address:	Street Address:
City, State, Zip:	City, State, Zip: Cathlamet, WA 98612
Phone: Fax:	Phone: 360-795-3271 Fax: 360-795-0545

Describe the record(s) to be disclosed:

___ Health Records ___ Special Education Records

___ Psychological/Counseling Records ___ Transcriptions

___ other (specify):_____

The reason for disclosing the record(s) is:

_____

_____

I understand that this information obtained 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. Please note that 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 (HIPPA).

This authorization is valid from___/___/___ to ___/___/___.

Note: For release of medical records, the authorization can be no longer than 90 days after this auth. Is signed.

I understand that my consent for the release of records is voluntary and I can withdraw my consent at any time in writing. Should I withdraw my consent, it does not apply to information that has already been provided under the prior consent for release.

Parent/guardian signature:_____Date:_____

Address:_____ Phone:_____