AUTHORIZATION FOR RELEASE OF HEALTH CARE AND/OR EDUCATION INFORMATION

Spokane Public Schools
excellence for everyone

Student #: _____

Student's Name: _____ **Birthdate**: _____

Date: _____ **School**: _____

I authorize the release of the information described below to be released FROM and sent TO the following:

Information to be released FROM:

_____
Name of facility/agency or provider

_____
Address

_____
City, State, Zip Code

_____
Phone

Information to be released TO:

_____
Name(s) of recipient(s)

_____
Name(s) of recipient(s)

_____
Name(s) of recipient(s)

_____
Address

_____
City, State, Zip Code

_____
Phone

Specific information to be released: _____

_____

_____

Purpose for which disclosure is being made: _____

_____

_____

Specific Minor Patient Authorization

*If the student is a minor but is authorized to consent to health care without parental consent under federal and state laws, only the student shall sign this form (RCW 70.02.030).

☐ HIV/AIDS, STD's status, diagnosis, treatment	(consent may be given by student 14 years of age)
☐ Family planning/abortion	(consent may be given by any age student)
☐ Alcohol/drug treatment	(consent may be given by student 13 years of age)
☐ Mental health services	(consent may be given by student 13 years of age)

My Rights I understand the following:
I have a right to request and receive a Notice of Privacy Practices from the above named provider. I may inspect and receive a copy (a nominal fee may be charged). I understand that I do not have to sign this authorization in order to get health care benefits (treatment, payment, enrollment, or eligibility for benefits) except if I receive health care when the sole purpose of the health care is to create health information for a third party. I can revoke this authorization at any time in writing but the revocation will not apply to information already used or disclosed. I recognize that this information, once received by the school district, may no longer be protected by the HIPAA Privacy Rule and become educational records protected by the Family Education Rights and Privacy Act (FERPA), but will be handled in compliance with applicable state and federal laws and school district policies and procedure. The provider must make the health care information available within 15 working days after receiving the request or notify the patient of any delay (RCW 70.02.080).

This Authorization expires with the end of the school year or on ____/____/____, whichever is sooner.

_____ _____
Signature of patient/legal representative (or student* if appropriate) Date

_____ (____) _____
Relationship to patient Phone Number