

**Shoreline School District
Shoreline, Washington 98155-2148**

AUTHORIZATION FOR EXCHANGE OF CONFIDENTIAL MEDICAL INFORMATION

To Parents: We can help you better if we are able to work with health care providers and agencies that know you and your family. By signing this form, you are giving permission for these individuals, clinics, or organizations to share information with those school personnel authorized by you.

Date _____ Student _____ Birth date _____ Grade _____
Parent name _____ School Meridian Park School

I hereby authorize the exchange of confidential medical records regarding the above named student for the purpose of educational planning and needs assessment between the Shoreline School District and

Name of school district/agency/other _____	Name of school district/agency/other _____
Address _____	Address _____
Phone number _____ FAX number _____	Phone number _____ FAX number _____

I understand that my express consent is required to release any health care information relating to testing, diagnosis, and/or treatment for HIV/AIDS, sexually transmitted diseases, psychiatric disorder/mental health, or drug and/or alcohol use.

I understand that (1) this release, unless limited by me in writing, extends to all aspects of treatment as listed below; (2) I may give written cancellation of this release at any time, but this cancellation will not affect any information that was released before the cancellation; (3) this information is confidential and will be treated in a confidential manner and will not be transmitted to a third party without my permission; and (4) this release, unless cancelled previously, expires 90 days after the date it is signed.

Initial	Information Requested (Initial all that apply)
	Medical records and/or information, including phone contact
	Mental health services; including psychiatric information [13 years of age; student consent required]
	Alcohol/drug information/treatment [13 years of age; student consent required]
	Family planning/abortion [student consent required]
	HIV/AIDS status, diagnosis, treatment [14 years of age; student consent required]
	Other, as listed: Educational information

Staff who have my permission to access this information [name/position must be listed]:

Donna M. Allred, RN	School Nurse	Teacher
Flip Herndon/J. Hoehna/A. Jessee	Building Administrator	School Counselor
	Sp Ed Teacher	SLP
B. Cary-Hamby/L. Scott/B. Wright	School Psychologist	OT/PT
	Family Advocate	Health Assistant

PLEASE RETURN TO:

Meridian Park School	
Name/Position Donna Allred, RN; School Nurse	
Address: 17077 Meridian Avenue North Shoreline, WA 98133	
Phone number (206)368-4124	FAX number (206)361-4259

Date _____ Consent expires in 90 days on _____

Parent/Guardian/Adult student signature

Student signature, if required

Address

Phone number

Copy : Parent Providers, as appropriate Compliance File