

Request for Sending Personally Identifiable Records

3122.3XE

I, _____ D.O.B. _____ Student # _____ hereby authorize the Yakima School District to:

<input type="checkbox"/> Obtain Information From: <input type="checkbox"/> Disclose Information To:	This request includes records from the following category or will be stored in that category:
Specific Person (if known) _____ Agency/School _____ Street Address _____ City, State, ZIP _____ Telephone _____ Fax _____	<input type="checkbox"/> Transcript or Cumulative Folder (custodian for release: principal designee or counselor). <input type="checkbox"/> Immunization and Screening Records Folder (custodian for release: any of the above). <input type="checkbox"/> Supplementary Folder (custodian for release: principal, special education director or designee). <input type="checkbox"/> Discipline Folder (principal or designee) <input type="checkbox"/> Confidential Health Records Folder (custodian for release: school nurse). <input type="checkbox"/> Other _____

This request and authorization applies to the following (check boxes):

- | | | |
|--|---|---|
| <input type="checkbox"/> Intake Assessment | <input type="checkbox"/> Discharge Summary | METHOD: |
| <input type="checkbox"/> Treatment Plan | <input type="checkbox"/> Pertinent Medical or Mental Health Records | <input type="checkbox"/> Read or Review |
| <input type="checkbox"/> Progress Notes | <input type="checkbox"/> Adoption or Foster Care | <input type="checkbox"/> Provide Copies |
| <input type="checkbox"/> Psychological/Psychiatric | <input type="checkbox"/> Records | <input type="checkbox"/> Orally Communicate |
| <input type="checkbox"/> Evaluation | | Date Range of Information Requested: _____ |
| <input type="checkbox"/> Other (specify) _____ | | |

Purpose of the request: _____

Please reply as soon as possible so that student service is expedited.

I understand

- that my records are protected under Federal and Washington State law, especially the Family Education Rights and Privacy Act (FERPA) and Health Insurance Portability and Accountability Act (HIPAA) and cannot be disclosed for purposes other than that stated above without my written authorization unless otherwise provided for in the regulations;
- that express consent is required to release the above-mentioned health care information; disclosure covers information about the student's status as a patient. For particular information and ages, the student's consent may be required as follows:
 - General Health Information 18 yrs of age – student consent
 - HIV/AIDS/STD 14 yrs of age – student consent
 - Family planning/abortion no age limit – only student consent
 - Alcohol/drug Treatment In-Patient 14 yrs of age – student consent
 - Out-Patient 13 yrs of age – student consent
 - Mental Health Services 13 yrs of age – student consent
- that the information used or disclosed may be subject to re-disclosure by relevant special education or health teams;
- that third party health information cannot be forwarded and will not be released by the school district;
- that I will be given a copy of this signed authorization and have the right to inspect or to copy the information to be used or disclosed, being charged a reasonable fee for this provision; and
- that I may revoke this authorization at any time by checking the revoked box below, dating and initialing it.

Client/Student Signature _____	<input type="checkbox"/> Copy given to client/student	Initials _____
Parent(s)/Guardian(s) Signature _____	<input type="checkbox"/> Copy refused by client/student	Initials _____
Description of Authority <input type="checkbox"/> Parent <input type="checkbox"/> Guardian <input type="checkbox"/> DCFS <input type="checkbox"/> Other _____	<input type="checkbox"/> Revoked. Date _____	Initials _____
This release expires on _____ or after ninety (90) days unless updated.		

Authorized district representative _____ Date Signed _____

School or Program _____ Address _____

Telephone _____ Fax _____