

CONSENT FOR MUTUAL EXCHANGE OF INFORMATION

Student name _____ Birth date _____ Student # _____
Serving school _____ Age _____ Gender _____ Grade _____
Home school _____ Date: _____

I hereby authorize the exchange of records between:

_____	<u>Denise Reed</u>
<i>Name of agency/person</i>	<i>Staff Name</i>
_____	<u>Home Hospital Coordinator</u>
<i>Street Address</i>	<i>Staff Position</i>

<i>City/State/Zip</i>	
_____	<u>School Special Services District Office</u>
<i>Phone</i>	<u>360-709-7049</u> <u>360-709-7042</u>
_____	<i>Phone</i> <i>Fax</i>
<i>Fax</i>	

Check all record types to be released:

- | | |
|--|--|
| <input type="checkbox"/> Health records | <input type="checkbox"/> Psychological and counseling records |
| <input type="checkbox"/> Special Education records | <input type="checkbox"/> Immunization |
| <input type="checkbox"/> Evaluations and reports | <input checked="" type="checkbox"/> Other <u>Home/Hospital</u> |

The reason for exchanging the record(s) is:

- | | |
|---|--|
| <input type="checkbox"/> Eligibility Verification | <input type="checkbox"/> Evaluation/Reevaluation Eligibility Determination |
| <input type="checkbox"/> Educational Placement | <input checked="" type="checkbox"/> Other <u>Home/Hospital</u> |

The 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 is protected under FERPA privacy standards by a school district and not the Health Insurance Portability and Accountability Act (HIPAA).

You do not need to sign this authorization. Refusal to sign the authorization will not adversely affect your ability to receive services. I understand that it is my right to request a copy of all information and contest any information I feel is incorrect.

This consent and authorization is valid for 90 days from the date of parent/adult student signature. Consent may be withdrawn at any time in writing, except where information has already been released based upon my authorization.

Parent/Guardian Date

Student (if over age 13)