CASHMERE SCHOOL DISTRICT
REQUEST AND AUTHORIZATION FOR RELEASE AND/OR EXCHANGE OF INFORMATION
(WAC 392-172-422)

PURPOSE: As a parent or guardian you have the right to give permission or not give permission for the release of your child's records with other persons or agencies. This request provides you with the opportunity to approve or not approve such a request unless release of records is allowed under one of the exceptions under the rules implementing the federal Education Rights and Privacy Act (for example, transfer of records from one school district to another). It also provides you the opportunity to talk with the school district and ask for an explanation as to why the information is being requested and by whom.

Student Name: ____ Date: ______________________

Student DOB: ____ School District: **Cashmere School District**

I hereby authorize the release of records:

FROM:

____
Name of District and/or Agency

____
Street Address

____
City, State, Zip

Please FAX the records to:
ATTN:______________________ (509) 782-__________

TO:

Cashmere School District / ______________
Name of School District / Individual

____
Street Address

Cashmere, Washington 98815
City, State, Zip

For medical related questions, please call:
District Nurse, Amber Varrelman: (509) 782-2001

General Medical/Special Education Information to be Disclosed (check):

□ **Special Education Records (IEP/Evaluation) to include:**
- Social/Emotional Evaluation
- Psychological Evaluation
- Speech/Language Evaluation
- Occupational/Physical Therapy Evaluation

□ **504 Reports**

□ **Medical and Clinical Records to include:**
- Clinic Notes
- Discharge Summaries
- Operative Reports
- Other: (Specify)______________________
- Other: Communication (by phone or in person)

Your signature below means you understand and agree to the following:

- 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 understand that (a) I must revoke my authorization in writing and may do so by completing and signing a revocation of authorization form with my health care provider; and (b) if I revoke my authorization, I understand that it will not affect any actions already taken by the health care provider based on this authorization.
- Information disclosed under this authorization may be redisclosed by the recipient and will no longer be protected by the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Records received by the Cashmere School District, however, are protected from redisclosure under the Family Education Rights to Privacy Act (FERPA).

This authorization is valid from ______________________________ to ______________________________.
Date *Date*

NOTE: Authorizations for release of medical or special education records are valid for one calendar year, unless otherwise specified above. If a date range is not provided, the authorization expires 365 days from the date this authorization is signed. I understand that my consent for the release of records is voluntary and that 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 this authorization/release.

______________________________ ______________________ ______________
Signature of Student's Parent/Guardian Relationship to Student Date

______________________________ ______________
Signature of Student, if applicable Date