Authorization for Exchange of Medical Information

SECTION I- INFORMATION REQUESTED FROM

NAME:	NAME OF PERSON DISCLOSING INFORMATION:
AGENCY : ________________	
ADDRESS: ________________	TITLE:

Name of Student: Birth Date: Date:

Specific nature of information to be disclosed:

SECTION II - AUTHORIZATION

I hereby authorize the release of medical information as described in Section 1 to the individuals who are affiliated with the school/agency indicated in Section Ill.

This authorization expires on: _______________________________

Parent Signature Date

Student Signature Date

If the student is a minor authorized to consent to health care without parental consent under federal and state law, only the student shall sign this authorization form.

SECTION Ill - AGENCY RECEIVING INFORMATION

AGENCY/SCHOOL: WEST VALLEY SCHOOL DISTRICT **NAME/POSITION**:_______________________________ **FAX NUMBER**:_________________________________ **PHONE:**_____________________________________ **ADDRESS:**____________________________________	This information disclosed to you is protected by state and federal law. You are prohibited from releasing it to any agency or person not listed on this form without a specific written consent of the person to whom it pertains. A general authorization for release of medical or other information is not sufficient. See chapter 70.02 RCW Envelope shall be marked “confidential”