PURPOSE: As a parent, guardian or student, 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 Family Education Rights and Privacy Act, FERPA, (for example, transfer of records from one school district to another).

AUTHORIZATION FOR RELEASE OF SPECIAL EDUCATION / MEDICAL RECORDS

Student name: ______________________ Date: ______________________

Student DOB: ______________ School District: Cascade #228

I hereby authorize the release of records:

To/From:	To/From: **Cascade School District Special Education**
Name of agency/person	*Name of agency/person*
	520 Pine Street
Street Address	*Street Address*
	Leavenworth, WA 98826
City, State, Zip	*City, State, Zip*
	(509) 548-4004 / (509) 548-8116
Phone, Fax	*Phone, Fax*

Describe the records to be disclosed:

- ☐ Health Records
- ☐ Psychological and Counseling Records
- X Special Education Records
- ☐ Transcripts
- ☐ Communication/Exchange of information between agency and school
- ☐ Other (specify): ______________________

Release Requiring Specific Consent: Specific consent is required for release of the following information. Student consent is also required at the ages specified in parentheses below. Mental health records are protected under RCW 71.05.390 and Chapter 71.34 RCW. Drug and alcohol abuse and treatment records are protected under 42 C.F.R. § 2; Information related to HIV/AIDS or sexually transmitted diseases is protected under RCW 70.24.105.

I specifically authorize the release of records relating to:

- ☐ Reproductive Care (student consent always required)
- ☐ Sexually Transmitted Diseases or HIV/AIDS (age 14 and older)
- ☐ Mental Health/Illness (age 13 and older)
- ☐ Drug/Alcohol Abuse (age 13 and older)

The reason for disclosing the record(s) is:

- ☐ An Evaluation or Reevaluation Process
- ☐ A Program Review
- ☐ An IEP is being developed
- ☐ Other (specify): ______________________

By signing this medical records or information disclosure authorization, I understand that the provider of such records or information cannot guarantee or assure that such records or information will not be further release or re-disclosed to third parties by the recipient. I also understand that the provider cannot guarantee that such records or information remain protected by federal or state law. I understand that when such records or information are provided to a school district where my student is enrolled, further disclosure of such records or information no longer protected by the Health Insurance Portability and Accountability Act (HIPAA), may nevertheless be regulated under other federal law (such as the Family Educational Rights and Privacy Act of 1974 (FERPA)) or corresponding state law. I understand that once the information has been released according to the terms of this authorization, the information cannot be recalled.

To those receiving information under this authorization: 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 in this form without specific written consent of the person to whom it pertains. A general authorization for release of information is not sufficient. See Chapter 70.02.005-904 RCW. *Envelope should be marked "CONFIDENTIAL."*

This authorization is valid from: ______________ to ______________ .
Date *Date*

______________________________ ______________________________
Parent/Guardian Signature Date Student Signature Date