SOUTH WHIDBEY SCHOOL DISTRICT - SPECIAL PROGRAMS DEPARTMENT
5476 S. MAXWELTON RD. LANGLEY, WA 98260 Phone: (360) 221-6100 Fax: (360) 221-6272

Student:_____Birth date:_____School: _____Grd: _____

I hereby authorize the exchange of confidential information and the release of records between the South Whidbey School District and the agency/person(s) listed below:

_____
(Name of Agency/Person)

_____
Street Address

_____
City, State, Zip Code

_____
Phone number, Fax number

Check all record types to be released:
_____ Health/Medical Records _____ Special Education Records _____Psychological & Counseling Records

_____Transcripts _____ Other (specify) _____

The reason for disclosing the record(s) is: Educational Program and Planning

*If the student's records contain any of the following information, that student or student's authorized representative must express written consent by placing a check mark below and signing:
_____ HIV/Aids status, diagnosis, treatment (age 14 or older) _____ Alcohol/drug treatment (age 13 or older)WAC 392-172-422
_____ Family planning/abortion (no min. age) WAC 392-172-102&104 _____ Mental health services (age 13 or older) RCW70.02005-904

X

Signature of student or authorized student representative Date

I understand that 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 by the district is protected under FERPA privacy standards and not the Health Insurance Portability Accountability Act (HIPPA).

This authorization is valid from: _____ _____
Date Date

Note: **FOR RELEASE OF MEDICAL RECORDS, THE AUTHORIZATION CAN BE NO LONGER THAN 90 DAYS AFTER THIS AUTHORIZATION IS**

I understand that my consent for the release of records is voluntary and 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 the prior consent for release.

_____ _____
Parent/Guardian Signature **Date**

Purpose of Authorization for the Release of Records: As a parent or guardian you have the right to 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).

Send information to: ***South Whidbey School District /Special Services Fax 360-221-6272 marked "CONFIDENTIAL"*** *Rev. 6/2017*

The South Whidbey School District #206 does not discriminate on the basis of sex, race, creed, religion, color, national origin, age, marital status, honorably discharged veteran or military status, sexual orientation including gender expression or identity, the presence of any sensory, mental, or physical disability, or the use of a trained dog guide or service animal by a person with a disability in its programs and activities and provides equal access to the Boy Scouts and other designated youth groups. The following employees have been designated to handle questions and complaints of alleged discrimination: Affirmative Action/Title IX/ RCW 28A.640 /RCW 28A.642 compliance officer, Dan Poolman, dpoolman@sw.wednet.edu, or Section 504/ADA coordinator, Jeff Fankhauser, jfankhauser@sw.wednet.edu, 5520 Maxwelton Road, Langley, WA 98260, 360-221-6100