MUTUAL EXCHANGE

I, _____, authorize the mutual exchange of information between:

Agency: _____

Address: _____

_____

and Seattle School District No. 1. School Attending: _____
Student Health Services
Mail Stop 31-650 Phone: (206) 252-0750
P.O. Box 34165
Seattle, Washington 98124-1165 FAX: (206) 252-0751

Attention: _____

regarding my child _____ Birth Date: _____
for the following purposes: This child has been identified for evaluation of a possible health concern or psychological/educational need. Any information you can provide will assist us in determining future health and educational services and will be kept confidential. Your prompt attention will help to ensure that we will meet our time lines for safety and services to this child.

- ” Medical History/Present Health Status
- ” Social/Emotional Evaluation
- ” Hospitalization Records
- ” Specialist’s Report
- ” Immunization Records
- ” Vision/Hearing Evaluation
- ” Speech/Language Evaluation
- ” Occupational/Physical Therapy Evaluation
- ” Special Education Records
- ” Other: _____

U **Specific Authorizations:** This consent ” does ” does not allow for the release of specific information as indicated below:

- ” Mental Health/Psychiatric Care
- ” HIV (AIDS) Testing/Diagnosis/Treatment
- ” Drug & Alcohol Abuse Diagnosis or Treatment
- ” Confirmed STD Test Results and/or Treatment

I understand that any records that contain information regarding mental health are protected by state law (RCW 71.05.390); drug/alcohol abuse or treatment records are protected under federal confidentiality laws (42 CFR 2); HIV/AIDS (or) confirmed STD tests or treatment records are protected by state confidentiality laws (RCW 70.24).

This information released covers the periods of _____ to _____ and shall expire, without my expressed revocation, on the 90th day from the date of my signature. I understand that once the health information I have authorized to be disclosed reaches the noted recipient, that person or organization may redisclose it, persuent to the Family Educational Rights Privacy Act (FERPA).

I understand that I may revoke this consent and authorization at any time unless action has already been taken based on this authorization. I also understand that I may inspect or copy information to be disclosed.

Signature	Relationship to Student	Date

Reference: WAC 392-172-422, -424

JL:HF:jb:wp:exchange.001