Bremerton School District 100-C
Health Services Department

AUTHORIZATION FOR RELEASE OF MEDICAL/EDUCATION INFORMATION

TO PARENTS: We can help you better if we are able to work with health care providers and agencies that know you and your family. By signing this form, you are giving permission for these individuals, clinics or organizations to share information about your child's health and education.

I authorize release of the medical/educational records indicated below of:

____

Student's Name: LAST FIRST MIDDLE INITIAL **BIRTH DATE**

Social Security Number (if pertinent to student identification, i.e. Naval Hospital**):** ________-________-________

REQUESTING INFORMATION FROM:

____

Name/Institution/Agency Address City State Zip Code

____

Name/Institution/Agency Address City State Zip Code

____

Name/Institution/Agency Address City State Zip Code

Nature of information to be disclosed: ____

____

Records to be released to:

Bremerton School District 100-C
Health Services Department
134 Marion Avenue North
Bremerton, WA 98312-3542
Office: 360-473-1073 Fax: 360-473-1043

Name	Job Title	Name	Job Title
Carolyn Flack, R.N.	Health Services Technician	Debra Hyre, CRTT/LRCP	Health Services Technician
Anna Friedel, R. N.	Health Services Technician	Cecilia Adrian, R.N.	Health Services Technician
Charmain Campbell, R. N.	Health Services Technician	Ronda Caddell, R.N.	Health Services Technician
Sandra Dayley, R.N.	Health Services Technician	______________	______________
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Name	Job Title	Name	Job Title

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The agency and individuals listed on this release may exchange information about my situation ☐ yes ☐ no

This permission expires **90 DAYS** after the date it is signed for medical and **180 DAYS** for educational records.

This permission expires on: ____________________________________
Month / Day / Year

I understand I may cancel this authorization, in writing, at any time. However, I understand that the cancellation will not affect any information that was already released.

I understand that this information is confidential, is protected by state and federal law, and medical information requires parent/adult student consent before disclosure. I understand what this agreement means and I voluntarily approve the release of this information.

I understand that my expressed consent is required to release any health care information relating to testing, diagnosis, and/or treatment for HIV/AIDS, sexually transmitted diseases, psychiatric disorder/mental health, or drug and or/alcohol use. This authorization covers information about my child's/my status as a patient and includes records of (initial any that apply.)

	HIV/AIDS status, diagnosis, treatment	(14 years of age-student's consent)
	Family planning/abortion	(No age limit-student's consent)
	Alcohol/drug treatment	(13 years if age-student's consent)
	Mental health services	(13 years of age-student's consent)

Other, as listed:____

Relationship: ☐ Parent ☐ Student ☐Guardian ☐ Student's Authorized Representative/Surrogate Parent

____
Signature Date

To those receiving information under this authorization: This Information disclosed to you is protected by state and federal law. You are not authorized to release to any agency or person not listed on this form without 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.

This is a true copy of the original authorized document.

Signature Bremerton School District Staff Person ***Date***

2017 (dsh)