Bremerton School District

Authorization for Release of Medical/Education Information

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 the release of the medical/education records indicated below of:

Student: _____
Last Name *First Name* *Middle Initial* *Birthdate*

Social Security Number ***(if pertinent to student's 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

Delivery method for records: ☐ Fax ☐ Paper/Mail

Nature of information to be disclosed:_____

_____

_____

Records to be released to:

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

Anna Friedel, RN	Registered Nurse	Tameka Phelps, BSN, RN	Registered Nurse
Name	***Job Title***	***Name***	***Job Title***
Carolyn Flack, RN	Registered Nurse		
Name	***Job Title***	***Name***	***Job Title***
Debra Hyre	Health Technician		
Name	***Job Title***	***Name***	***Job Title***
Janet Wyatt, BSN, RN	Registered Nurse		
Name	***Job Title***	***Name***	***Job Title***
Sandra Dayley, RN	Registered Nurse		
Name	***Job Title***	***Name***	***Job Title***

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 if any apply)*:

- Family planning/abortion ____ (No age limit)
- Alcohol/drug treatment ____ (13 year old student's consent)
- Mental health services ____ (13 year old student's consent)
- Other, as listed: _____

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

_____	_____	_____
Print Name	***Signature***	***Date***

This section to be completed by BREMERTON SCHOOL DISTRICT STAFF:

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

Medical records permission expires on: _____
Date

Education records permission expires on: _____
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.

_____	_____	_____
Print Name	***Signature***	***Date***