Health Care / Treatment Provider Exchange of Health Information Authorization

2024-2025 School Year

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For questions and more information about this document, please contact the following:

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Release of information form for student health information.

Health Care/Treatment Provider
Exchange of Health Information Authorization
2024-2025 School Year

Provider Name _____ School Name _____

Provider Contact Person _____ School Contact Person _____

Provider Contact Email/Phone _____ School Contact Email/Phone _____

I authorize the protected health information described below to be disclosed by my/my child's provider and used by the above-listed school and/or school representative:

- ☐ Identifying Information: Name, DOB, Dates Admitted To/Discharged from Program
- ☐ Diagnosis
- ☐ Assessment, Evaluation, & Treatment Recommendation(s)
- ☐ Urinalysis/Drug & Alcohol Test Result(s)
- ☐ Treatment History, Compliance, & Progress
- ☐ Current Stressors, Triggers, or Challenges
- ☐ Discharge Summary & Continuing Care Plan
- ☐ Other Treatment Information: _____

Purpose of information exchange:

- ☐ Care Coordination
- ☐ Identification of Resources
- ☐ Assist in Placement Decision Making
- ☐ Other Purpose: _____

I understand that the purpose of sharing this health information is to support my/my child's treatment and education. I understand that this release does not impact my/my child's educational records protected by FERPA. This consent will make the above-listed health information available for exchange from the date of my signature until August 31, 2025. I further understand that I may revoke my consent by providing a written revocation to the Seattle School District and the above-listed Provider.

Student Name _____ Parent Name (Required for Student Under 13) _____

Signature _____ Date _____

Student Over 13 or Parent/Guardian