

# Health Care/Treatment Provider Exchange of Health Information Authorization 2026-2027 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, 2027. 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  
Student Over 13 or Parent/Guardian

\_\_\_\_\_  
Date