Health Care/Treatment Provider Exchange of Health Information Authorization 2023-2024 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, 2024. 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