WASHINGTON STATE
OUTREACH TEAM

AUTHORIZATION FOR RELEASE OF RECORDS

PURPOSE: As a parent, guardian or student, you have the right to give permission or not give permission for the release of your child's records with other persons or agencies. This request provides you with the opportunity to approve or not approve such a request unless release of records is allowed under one of the exceptions under the rules implementing the Family Education Rights and Privacy Act, FERPA, (for example, transfer of records from one school district to another).

Student name: ______________________________ Student DOB: ______________

School District: ______________________________ Today's Date: ______________

I hereby authorize the mutual release of records between:

Washington State Center for Childhood Deafness and Hearing Loss,
Attn: Outreach Coordinator, 611 Grand Blvd, Vancouver, WA 98661

School/Agency/Person Name:	Audiology Clinic/Provider:
District:	Organization:
Address:	Address:
City/State/Zip:	City/State/Zip:
Email address:	Email address:

Describe the records to be disclosed:

- ☒ Current 3 year evaluation report
- ☒ Current IEP or 504 Plan
- ☒ Audiogram / reports
- ☐ Other: ______________________
- ☒ Annual review of IEP (benchmarks)
- ☒ Behavioral assessments or plans
- ☒ CDHL consultation reports
- ☐ Other: ______________________

The reason for disclosing the record(s) is: Support in performing outreach consultative services requested by the district and/or family.

I understand that this information obtained will be treated in a confidential manner by the CDHL under the provisions of the Family Education Rights and Privacy Act (FERPA). FERPA prohibits disclosure of personally identifiable information without consent except in limited circumstances. Please note that if the request is for health or medical information, the medical information received by the CDHL is protected under FERPA privacy standards and not the Health Insurance Portability and Accountability Act (HIPAA).

Note: For release of medical records, the authorization can be no longer than 90 days after this authorization is signed. If no date is entered this consent will remain in effect for one year from the date of signature

This authorization is valid until: ______________________
(Date)

I understand that my consent for the release of records is voluntary and I can withdraw my consent at any time in writing. Should I withdraw my consent, it does not apply to information that has already been provided under the prior consent for release.

______________________________ ______________

Parent/guardian/adult student Signature Date