DeafBlind Program

Washington State School for the Blind

2214 E. 13th St. · Vancouver, Washington 98661-4120
(360) 696-6321 · FAX # (360) 737-2120

Two-Way Authorization for Release of Records

Student Name	Student DOB
District/Agency	Date

Check all records to be released:

Health/Medical Records   IEP/Special Education Records   IFSP

Other   Specify ______________________________

The reason for disclosing the records is to assist in determining special education eligibility and/or to plan for appropriate education/consultation.

I hereby authorize the release of medical and/or educational records between WSSB/WA Deaf-Blind Project and the agencies/providers.

I understand that the information obtained will be treated in a confidential manner and will not be transmitted to a third party without my permission. I also understand that it is my right to request a copy of all information and contest any information I feel is incorrect.

I understand any disclosure of information has the potential for further release or distribution by the recipient that may not be protected by confidentiality laws.

I understand that this information obtained will be treated in a confidential manner by the school district 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 district is protected under FERPA privacy standards by the school district and not the Health Insurance Portability and Accountability Act (HIPAA).

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.

This authorization is valid from ____________________ to ____________________
date   date

Note: For release of medical records, the authorization can be no longer than 90 days after this authorization is signed.

Yes, I would like to receive a newsletter with family connections and resources

Student/Parent/Guardian Signature	Date
Printed Name	Phone
Email address(s)	Address/City/State/Zip

Washington State School for the Blind

Agency/District and or Medical Provider Information

***Please provide fax number for secure transfer of information**

District/Agency ____________________ Contact Name ____________________

Address ____________________ **Fax*** ____________________

Email ____________________ Phone ____________________

Medical Facility ____________________ Contact Name ____________________

Address ____________________ **Fax*** ____________________

Email ____________________ Phone ____________________

Medical Facility ____________________ Contact Name ____________________

Address ____________________ **Fax*** ____________________

Email ____________________ Phone ____________________

Medical Facility ____________________ Contact Name ____________________

Address ____________________ **Fax*** ____________________

Email ____________________ Phone ____________________

Fax records to

(833) 903-0338

Contact

Tracey Bjerke

(360) 947-3297

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