Washington Sensory Disabilities Services

Authorization for Release of Records

PURPOSE: As a parent, guardian or student (aged 18 or older), you have the right to give, or not give, permission for the release of your child's records to 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.

CHILD's NAME _____ **Male** ___ **Female** ___ **CHILD'S DOB** _____

SCHOOL DISTRICT/AGENCY _____ **STATE STUDENT ID # (10 digits)** _____

I HEREBY AUTHORIZE THE EXCHANGE OF INFORMATION VERBALLY, IN WRITING, OR ELECTRONICALLY BETWEEN WSDS PROJECT STAFF AND THE AGENCIES/PERSONS LISTED BELOW FOR THE FOLLOWING PURPOSE(S):

Check one or more:

☐ Determining eligibility for WSDS project services
☐ Developing an appropriate IFSP/IEP
☐ Sharing evaluation/assessment results, progress notes
☐ Other (specify) _____

Washington Sensory Disabilities Services (WSDS)
Name of agency/person
800 Oakesdale Ave. SW
Street address
Renton, Washington 98057
City, State, Zip
(425) 917-7827 or (800) 572-7000 **(425) 917-7838**
Phone # Fax #

and

_____
Name of agency/person
_____
Street address
_____
City, State, Zip
( ) ( )
Phone # Fax #

and

_____
Name of agency/person
_____
Street address
_____
City, State, Zip
( ) ( )
Phone # Fax #

and

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Name of agency/person
_____
Street address
_____
City, State, Zip
( ) ( )
Phone # Fax #

and

_____
Name of agency/person
_____
Street address
_____
City, State, Zip
( ) ( )
Phone # Fax #

THE RECORDS TO BE EXCHANGED INCLUDE:
(check all that apply)

☐ Reports/Assessment for:
_____ Vision _____Hearing
☐ IFSP/IEP
☐ Relevant medical records
☐ Other (specify) _____

FOR QUESTIONS, CONTACT WSDS STAFF:

Puget Sound ESD:
800-572-7000 (or) 425-917-7827

North Central ESD:
509-665-2619

Central Washington University:
509-963-1131

wsds@psesd.org
www.wsdsonline.org

I understand that this information obtained will be treated in a confidential manner by Washington Sensory Disabilities Services project staff 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.

Neither treatment nor payment is dependent on a signed authorization.

Information disclosed may be subject to re-disclosure by an authorized recipient and privacy laws may no longer protect your information.

The following information is protected via HIPPA. Check each item below that you wish to be released:

☐ **HIV (AIDS virus)** ☐ **Sexually transmitted diseases**

☐ **Drug or alcohol abuse** ☐ **Psychiatric disorder or mental health**

☐ This authorization is valid for one year. Specify end date:_____

☐ If less than one year, this authorization is valid from: _____ to _____

Date Date

Requesting Records: From:_____ To:_____

Date 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 Signature Date Relationship to Child

_____ _____

Father's Name (if appropriate) Mother's Name (if appropriate)

_____ _____

Parent/Guardian Address Child's Address (if different)

_____ _____

City, State, Zip City, State, Zip

(_____) _____ (_____) _____

Phone(s) Phone(s)

_____ _____

Email Email