STATE OF WASHINGTON
WASHINGTON STATE SCHOOL FOR THE BLIND
2214 13th St. · Vancouver, Washington 98661-4120 · (360) 947-3297 · FAX # (833) 903-0338

- Washington Deaf-Blind Project -
Two-Way Authorization for Release of Records

Student name: _____ DOB: _____

I hereby authorize the release of medical and/or educational records between WSSB/WA Deaf-Blind Project and the agencies/providers listed on page 2:

Check all records types 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 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).

This authorization is valid from ____/____/_____ to ____/_____/_____.
Note: For release of medical records, the authorization can be no longer than 90 days after this authorization is signed.

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

_____ _____
Student/Parent/Guardian Signature Date

_____ _____
Street Address City, State, Zip

Obtained by: Washington Deaf-Blind Project

Please provide contact information for all relevant agencies and/or medical providers.
Return records to:

(Fax) 833-903-0338 or contact Khanh Huhtala at khanh.huhtala@wssb.wa.gov
(Phone) 360-947-3297

Name of Agency/Provider			
Address/City/Zip			
Phone #		Fax #	
Email			
Name of Agency/Provider			
Address/City/Zip			
Phone #		Fax #	
Email			
Name of Agency/Provider			
Address/City/Zip			
Phone #		Fax #	
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