CENTRAL KITSAP SCHOOL DISTRICT #401
HEALTH SERVICES
P.O. Box 8, Silverdale, WA 98383
Phone: 360-662-1070
Fax: 1-360-633-1688

AUTHORIZATION FOR EXCHANGE OF CONFIDENTIAL INFORMATION

Permission is hereby granted on behalf of _____
(Student Name)

D.O.B: _____ to mutually exchange any and all confidential information between the parties listed below:

Agency/Physician/Previous Schools	Health Services Department
	Central Kitsap School District
Address	P.O. Box 8
	Silverdale, WA 98383
City State ZIP	
Attn	Attn
	360-662-1070 1-360-633-1688
Phone Fax	Phone Fax

___ Medical information and/or health records to assist our School Health Consultant in the implementation of a health care plan for this student.

___ Other (specify): _____

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 believe to be incorrect.

Parent/Guardian Signature

Address Date

Student's signature (if 13 or older) Date

This authorization is valid for the current school year. I understand that authorizing the disclosure of this health information is voluntary. I understand that I can cancel this authorization at any time in writing. I understand that once the information has been released according to the terms of this authorization, that the information cannot be recalled. I understand that any disclosure of information carries with it the potential for further release or distribution by the recipient that may not be protected by federal confidentiality rules.