NORTHWEST ESD 189
Skagit Discovery

AUTHORIZATION FOR EXCHANGE OF CONFIDENTIAL INFORMATION

Student Name_____ **Date**_____
School District_____

Purpose for Information Exchange

Share Information to help improve or monitor a student's:
(Check as many as apply)

- ☐ **Health**
- ☐ **Behavior**
- ☐ **Academic performance**

Or

- ☐ **Other:**_____

I hereby authorize the exchange of confidential information with the agency/person(s) listed below:

Name of agency/person	Name of agency/person
Street address	Street address
City, state, zip	City, state, zip

Check all appropriate:

- ☐ **Health records**
- ☐ **Psychological and counseling records**
- ☐ **Special education records**
- ☐ **Transcripts**
- ☐ **Other (specify)**_____

School district staff who may access health records:

- ☐ **Program nurse**
- ☐ **Supervising teacher**
- ☐ **Program director/principal**
- ☐ **Transportation personnel**
- ☐ **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 feel is incorrect.

Parent/guardian Signature	Date
Street address	City, state, zip