SPOKANE
INTERNATIONAL ACADEMY

SIA HEALTH SERVICES
2706 E Queen Ave • Spokane WA 99217 • Telephone (509) 209-8730 • Fax (509) 209-8708

AUTHORIZATION FOR EXCHANGE OF HEALTH CARE INFORMATION

Patient/Student Name _____ School _____

Birthdate _____ Date _____

I hereby authorize the exchange of health and/or education information:

Between Employees of Spokane International Academy and:

Name of Facility _____ Phone _____ Name of Agency/Individual _____ Phone _____

Address _____ Address _____

City, State, Zip Code _____ City, State, Zip Code _____

Specific nature of information to be disclosed:

_____ _____

Purpose for which disclosure is being made:

_____

I hereby authorize the exchange of health care information as described above. I recognize that this information, once received by the school district, may no longer be protected by the HIPPA privacy rule and become educational records protected by the Family Education Rights and Privacy Act (FERPA), but will be handled in compliance with applicable state and federal laws and school district policies and procedures.

This authorization expires with the end of the school year or on ___/___/___, whichever is sooner. I may terminate this authorization in writing at anytime. I have a right to a copy of the authorization and may inspect and receive a copy of the disclosed or used information.

Parent Signature/Legal Representative _____ Date _____ Student Signature * _____ Date _____

*****If the student is a minor, but is authorized to consent to health care without parental consent under federal and state laws, only the student shall sign this form.

- ☐ HIV/AIDS, STDs status, diagnosis, treatment (consent may be given by student 14 years of age)
- ☐ Family planning/abortion (consent may be given by any age student)
- ☐ Alcohol/drug treatment (consent may be given by student 13 years of age)
- ☐ Mental health services (consent may be given by student 13 years of age)