North Kitsap School District
A Great Place to Live & Learn

Student Health Services
School Health Consultants
18360 Caldart Avenue NE
Poulsbo, WA 98370
Ph: (360) 396-3580
Fax: 1-888-784-3535

AUTHORIZATION FOR EXCHANGE OF CONFIDENTIAL INFORMATION

Permission is hereby granted on behalf of ____
(student name)

Date of Birth____/____/____ to mutually exchange any and all confidential information between the parties listed below:

________________________________	School Health Consultants
Agency/Physician/Previous Schools	North Kitsap School District
________________________________	18360 Caldart Ave. NE
Address	Poulsbo, WA 98370
________________________________	Attention: ______________________
City State ZIP	
________________________________	(360) 396-3580 1-888-784-3535
Phone Fax	Phone Fax

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

☐ ___Verbal exchange of information ___Written exchange of information

☐ 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 Date

____
Address

____
Student's Signature (if 13 or older) Date

I understand I have the right to revoke this authorization at any time. The revocation must be in writing and presented to the Health Services Dept. I also understand that the revocation will not apply to information already released in response to this authorization. I understand the revocation will not apply to circumstances where state or federal regulations require access to information. Unless otherwise revoked, this authorization will **expire 90 days for medical records and 180 days for educational records after the date of signature.**