Bainbridge Island School District

AUTHORIZATION FOR EXCHANGE OF CONFIDENTIAL MEDICAL INFORMATION

Today's Date: ______________________

Student Name: ______________________ Birth Date: ______________________

I hereby authorize the exchange of medical information regarding the above named student between:
(Authorization expires 90 days after date it is signed).

School/	______________________	Address/	______________________
Agency/	______________________		______________________
Individual	______________________		______________________

And:

Bainbridge High School 9330 NE High School Rd Bainbridge Island, WA 98110 (206)842-2634	Woodward Middle School 9125 Sportsman Club Rd Bainbridge Island, WA 98110 (206)842-4787	Sakai Intermediate School 9343 Sportsman Club Rd Bainbridge Island, WA 98110 (206)780-6500
Blakely Elementary School 4704 Blakely Ave Bainbridge Island, WA 98110 (206)842-4752	Ordway Elementary School 8555 Madison Ave NE Bainbridge Island, WA 98110 (206)842-7637	Wilkes Elementary School 12781 Madison Ave NE Bainbridge Island, WA 98110 (206)842-4411
	Commodore Options 9530 NE High School Rd Bainbridge Island, WA 98110 (206)780-1646	

Reason: ______________________

School staff involved in planning for the student:
(A printed list of Guidance/Multidisciplinary Team members may be attached to this form).

Name	Position	Name	Position
Name	Position	Name	Position
Name	Position	Name	Position

The statute on health care information access and disclosure (Chapter 70.02 RCW) allows the disclosure of medical information to school district staff in order to monitor a student's condition; design appropriate classroom, program, or transportation adaptations; and in general, provide a safe, therapeutic environment. School staff involved in planning for the student are to be listed by name and position. A general authorization for release of medical or other information is not sufficient for release of confidential medical information.

____
Signature of parent/guardian/or student

____
Relationship to Student

____
Address

____
City State Zip

Distribution: *Original to Releasing/Receiving School/Agency/Person*
Copies to: *Parent/Guardian or Student and BISD*

Form 12Med, 9/2008