BELLEVUE SCHOOL DISTRICT
Bellevue, Washington

AUTHORIZATION FOR RELEASE OF RECORDS/INFORMATION

Student: ______________________ Birthdate: ______________ Grade: ________

School: ______________________ Student No: ______________________

PURPOSE OF AUTHORIZATION FOR THE RELEASE OF RECORDS: As a parent or guardian you have the right to give permission or not give permission for the exchange of your child's records with other persons or agencies. This request provides you with the opportunity to approve or not approve such a request unless release of records is allowed under one of the exceptions under the rules implementing the Federal Family Education Rights and Privacy Act (for example, transfer of records from one school district to another).

I hereby authorize the mutual exchange of confidential information and the release of records among and between the Bellevue School District and the person(s) or agency listed below:

To/From: ______________________	From/To: ______________________
(Name of agency/person)	*(District employee/title and school or department)*
Street Address	*Street Address*
City, State, Zip	*City, State, Zip*
Phone number/Fax number	*Phone number/Fax number*

Check all record types to be released:

- ☐ Health/medical records
- ☐ Psychological and counseling records
- ☐ Special education records
- ☐ Transcripts
- ☐ Other (specify): ______________________

The reason for disclosing the record(s) is: ______________________

I understand that the information obtained by the Bellevue School District will be treated in a confidential manner under the provisions of the Family Education Rights and Privacy Act (FERPA). FERPA prohibits disclosure of personally identifiable information without consent except in limited circumstances. Please note that if the request is for health or medical information, the medical information received by the District is protected under FERPA privacy standards and not the Health Insurance Portability and Accountability Act (HIPAA).

Note: For release of medical records, the authorization will automatically expire 90 days from the date of signing.

I understand that my consent for the release of records is voluntary, and I can withdraw my consent at any time in writing. Should I withdraw my consent, it does not apply to information that has already been provided under the prior consent for release.

______________________ ______________________
Parent/guardian signature Date

______________________ ______________________
Street address City, State, Zip

Distribution: Nonschool Agency
Case Study File, ESC
School Supplemental Record
Parent or Adult Student