South Kitsap School District

Student Success

Request for Mutual Release and/or Exchange of Information

Please Print Date:_____

Student Name:_____

Birthdate:_____ SSID#_____ Age:_____

School:_____

I authorize the mutual release and/or exchange of pertinent information regarding the above-named student between you and the South Kitsap School District. The information to be released is as follows:

☐ Professional Records: Reports by psychologist, communication disorders specialist, physical therapist, occupational therapist, counselor, nurse, etc.

☐ Medical Records: Related to (specify below):
_____

_____

☐ Other:
_____

Information To Be Sent From:

_____

_____

_____

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

Please Send Information To:

_____

_____

_____

May Be Shared With:

_____

Name Title

Parent/Guardian Name:_____ Date:_____
(Please Print)

Address:_____

Signature:_____ Relationship to Student:_____

In accordance with the Federal Privacy Act, information sent or received by the South Kitsap School District may not be shared with any other party without the written consent of parents/guardians or the student, if at least 18 years old. The granting of permission is voluntary on the part of the parents/guardians or adult student and may be revoked at any time. This form is valid for a period of one (1) calendar year or ninety (90) days if medical records.

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