BEAVERTON
SCHOOL DISTRICT
THRIVE • CONTRIBUTE • EXCEL

Youth Services Team (YST)
Authorization to Use/Disclose
Educational Records

Dear Parent/Guardian:

The following entities request your permission to use, exchange, and/or disclose educational and/or protected information regarding your child: *Beaverton School District, Washington County Health and Human Services, Northwest Regional Education Service District, Lifeworks NW, Western Psychological, Youth Contact, Inc., Morrison Center, Kaiser Permanente, Washington County Juvenile Department, Washington County Sherriff's Office, Beaverton Police Department, Child Welfare Division – State Department of Human Services, Emmanuel Hospital, Providence Health Systems.*
*Additional entities:*____.

______________________________ ______________ ____________________
Name of Student (please print) Grade Student ID No.

____
Name of Parent/Guardian (please print)

By *initialing* below, I authorize the aforementioned entities to:

___ Send/disclose protected health information ___ Send/Disclose educational information

___ Receive/Use protected health information ___ Receive/Use educational information

___ Use/Disclose Drug/Alcohol diagnosis, treatment or referral information

___ Use/Disclose Mental Health related information

I understand that:

a. The information exchanged subject to this authorization may be used for the purpose of planning and coordinating services delivery for my family.
b. This authorization is voluntary and I may refuse to sign it without affecting my child's health care or related services.
c. I have the right to request a copy of this form after I sign it as well as inspect or copy any information to be used and/or disclosed under this authorization (if allowed by state and federal law. See CFR 164.524)
d. I may revoke this authorization at any time by notifying ______________ in writing. However, it will not affect any actions taken before the revocation was received or actions taken based on the previously shared information.
e. Federal privacy rules for protected health information apply only to health plans, health care clearinghouses or health care providers. If I authorize disclosure of medical information to other agencies or individuals the disclosed information may no longer be protected by federal privacy regulations.
f. Federal privacy rules for education information apply only to schools. If I authorize disclosure of educational information to other agencies or individuals the disclosed information may no longer be protected by federal privacy regulations.

This authorization expires on ________________ (not to exceed one year from date of signature below).

I consent to the use/disclosure of the above information. I understand that the use of this information for any reasons other than the expressed reasons stated above is prohibited. This consent is subject to revocation at any time, except to the extent that action has been taken based on information that has already been disclosed.

______________________________ ______________________
Signature of Student Date

______________________ ______________________ ____________________
Signature of Parent/Guardian Relationship Date
(REQUIRED IF EDUCATIONAL RECORDS OR INFORMATION IS BEING DISCLOSED) **2/1/12**