Enumclaw SCHOOL DISTRICT

Student Support Services
2929 McDougall Ave.
Enumclaw, Washington 98022

Authorization for Exchange of Confidential Information

Student's Name: _____ DOB:_____ Building: _____

I hereby authorize the exchange of confidential information with the agency/person(s) listed below:

To:

_____ Name of School/Agency/Person(s)	_____ Phone Number
_____ Street Address	_____ Fax Number
_____ City, State, Zip	_____ email

Check all appropriate items:

- ☐ **Transcripts**
- ☐ **Psychological and Counseling Records**
- ☐ **Special Education Records**
- ☐ **Health Records**
- ☐ **Other (Specify)** _____

The purpose for disclosing records is to determine appropriate educational placement and services.

Revocation: I understand that I may revoke this authorization at any time by notifying Enumclaw School District Student Support Services in writing. I understand that the revocation will not apply to information that has already been released in response to the authorization

Expiration: This authorization will expire one year from date of signature, or on this date _____.

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.

_____ Parent/Guardian Name (Printed)	_____ Phone Number
✓_____ Parent/Guardian Signature	_____ Work Phone Number
_____ Street Address	_____ City, State, Zip
✓_____ Student Signature (age 13 and older, if applicable)	_____ Date

Send Information to:

Student Support Services
Enumclaw School District
2929 McDougall Avenue
Enumclaw, Washington 98022

Fax: **360-802-7140**
Phone: **360-802-7125**
Sheila_fend@enumclaw.wednet.edu

Form faxed/mailed by:_____ Date: _____