**Olympic Educational Service District 114**
Early Learning Department
105 National Ave N Bremerton, WA 98312
(360) 478-6887 · 1-800-201-1300 · FAX (360) 405-5808

# Authorization to Release and Exchange Confidential Information

## Authorization to Disclose the Records of:

Child/Participant Name: _____ Date of Birth: _____

Parent/Guardian Name: _____ Phone Number: _____

**Reason for Release of Information**: At the request of the parent/guardian for the health, safety, and educational purposes of their child while enrolled in the OESD 114 Early Learning Program.

**I authorize mutual exchange of information about my child/participant as described below.**

Organization/Office: _____ Contact Name/ Provider: _____

Phone: _____ Fax: _____

## Release: I authorize the following records and/or information be disclosed regarding:

☐ IFSP/IEP Documents/Evaluations ☐ Medication Administration ☐ Medical Treatment Records

☐ Education Records ☐ Immunization Records ☐ Dental Treatment Records

☐ Eligibility Documentation ☐ Attendance and Participation ☐ Other: _____

## My permission is valid for ONE CALENDAR YEAR from signature date.

- I may revoke or withdraw my permission in writing at any time. I understand this will not affect information already disclosed.
- I understand that these records will be treated as confidential by the OESD 114 Early Learning Program.

| Authorization Signature | Printed Name | Date |
|---|---|---|
| Relationship to Child | Phone Number | Organization *(if applicable)* |

If I am not the person who is the subject of the records, I am authorized to sign because I am the:

☐ Parent ☐ Legal Guardian ☐ Other: _____

*One Form per Organization/Office*

*Updated August 2022*