

Olympic Educational Service District 114

OESD 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:		Dat	Date of Birth:	
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 with the organization/office listed below.				
Organization/Office:	Contact Name/ ization/Office: Provider:			
Phone:	Fax:			
Release: I authorize the following records and/or information be disclosed regarding:				
 IFSP/IEP Documents/Evaluations Education Records Eligibility Documentation My permission is valid for ONE CALENT.	□ Immunizatio □ Attendance	n Records and Participation	 Medical Treatment Records Dental Treatment Records Other: 	
 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 If I am not the person who is the subject of the records Parent Legal Guardian		s, I am authorized to siؤ _	Organization (<i>if applicable</i>) gn because I am the:	
Full name of OESD staff contact:		taff Phone number:		