



# Snoqualmie Valley Public Schools

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## CONSENT FOR DISCLOSURE OF MEDICAL RECORDS AND HIV/AIDS OR HBV STATUS OF

\_\_\_\_\_  
(Name of School District Employee)

I, \_\_\_\_\_, have informed \_\_\_\_\_  
(Name of parent/guardian) (Name of school district employee)  
of the HIV/AIDS or HBV status.

\_\_\_\_\_  
(Signature)

\_\_\_\_\_  
(Date)

I, \_\_\_\_\_, request/authorize, \_\_\_\_\_  
(Name) (Name of health care provider)  
to disclose medical information, including test results or other information relating to my HIV/AIDS or HBV status to \_\_\_\_\_

\_\_\_\_\_  
(Name of district employee)

\_\_\_\_\_  
(Signature)

\_\_\_\_\_  
(Date)

I, \_\_\_\_\_, also request/authorize, \_\_\_\_\_  
(Name of parent/guardian) (Name of district employee)  
to disclose the HIV/AIDS or HBV status to the following school district employee or designees.

Name	Job Title	Name	Job Title
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

You are prohibited by state law from making any further disclosure of this information without the specific written consent of the person to whom it pertains or the parent or legal guardian of the Minor Child to whom it pertains, unless otherwise permitted by state law. A general authorization for release of medical or other information is **NOT** sufficient for this purpose.

This consent is subject to revocation at any time except to the extent that the individuals authorized to make the disclosure have already taken action in reliance on it. If not previously revoked, this consent will terminate in 90 days.

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Printed Name

**NOTICE**

**CONFIDENTIALITY OF HIV/AIDS OR HBV INFORMATION**

You have been authorized on the reverse side of this document to receive information regarding the HIV/AIDS or HBV status of the named individual or Minor Child. The confidentiality of this information is protected by state law. You are prohibited by state law from making any further disclosure of this information without the specific written consent of the person to whom it pertains or the parent or legal guardian of the Minor Child to whom it pertains, unless otherwise permitted by law. A general authorization for release of medical or other information is **NOT** sufficient for this purpose.

Unauthorized disclosure of the HIV/AIDS or HBV status of the named individual or Minor Child is a gross misdemeanor. The maximum term of imprisonment for a gross misdemeanor is one year; the fine can range up to \$5,000. In addition, any person aggrieved by an unauthorized disclosure may bring a civil lawsuit for damages in Superior Court.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date