PENINSULA SCHOOL DISTRICT

Release of Information Regarding HIV/AIDS, Hepatitis B, Hepatitis C, or Other Sexually Transmitted Disease – STUDENT

(print name of student)	(date of birth)	(student number)

The above named student has been diagnosed as having:

☐	Human Immunodeficiency Virus Infection (HIV)
☐	Acquired Immunodeficiency Syndrome (AIDS)
☐	Hepatitis B
☐	Hepatitis C
☐	Other Sexually Transmitted Disease (Describe):

I authorize disclosure of information about this diagnosis to:

Position	Print Name of Staff Member Receiving Information	Initials of Student/Parent Releasing Information
Building Principal		
Student Services		
School Nurse		
Counselor		
Other:		

This release of confidential health information expires 90 days from the date signed.

"This information has been disclosed to you from records whose confidentiality is protected by state law. State law prohibits you from making any further disclosure of such records without the specific written consent of the person to whom it pertains, or as otherwise permitted by state law. A general authorization for the release of medical or other information is NOT sufficient for this purpose." (RCW 70.24.105 [5])

Student Signature (14 years of age) Parent/Guardian Signature (under 14 years)	Date

This release will be stored in the student's medical file in Student Services.