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| **PURPOSE:** Signing this form will help connect students to services they may be eligible for to support them as they move from the public school system to adulthood. If your consent is provided, the Office of Superintendent of Public Instruction (OSPI) will share information about the student to the state transition agencies named within this document to support transition and post-school services. |

**CONSENT TO SHARE STUDENT INFORMATION WITH STATE TRANSITION AGENCIES**

***TO BE FILLED OUT BY SCHOOL OR DISTRICT STAFF ONLY IF PARENT (OR ADULT STUDENT) CONSENT IS NOT PROVIDED***

If the Parent/guardian/adult student did not consent to authorize OSPI to share the student’s information with the state transition agencies named within this document, please include the name of the school or district staff person who discussed this form with the parent (or adult student) and the date of the conversation:

|  |  |  |
| --- | --- | --- |
|  |  |  |
| *School or District Staff Name* |  | *Date* |

*\*\* The Consent to Share Information with State Agencies Form is a voluntary form being piloted in the 2023-2024 school year. This form will be fully implemented by the 2024-2025 school year and beyond. IEP teams should review this form as part of the IEP meeting for all students who have an IEP Transition Plan (per WAC 392-172A-03090 (1)(k)).*

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| --- | --- | --- | --- |
| Student name: |  | Date: |  |
|  |  |  |  |
| Student DOB: |  | School District: |  |
|  |  |  |  |
| **Student information may include:** |
| * Name
* Date of Birth
* Disability Category
* Grade
* Expected Graduation Date
* School District
* School
* ESD
* County
 |
| I understand that this information obtained will be treated in a confidential manner by the recipients under the provisions of the Family Education Rights and Privacy Act (FERPA). FERPA prohibits disclosure of personally identifiable information without consent except in limited circumstances. Please note that if the request is for health or medical information, the medical information received by the district is protected under FERPA privacy standards and not the Health Insurance Portability and Accountability Act (HIPAA).

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| This authorization is valid for up to five years, starting on: |  |
|  | *Date* |

I hereby authorize the Office of Superintendent of Public Instruction (OSPI) to share my / my student’s information with the Department of Social and Health Services, County agencies, and the Department of Services for the Blind and any other state agency working with individuals with intellectual and developmental disabilities. I understand that I can rescind this authorization at any point by contacting the IEP team.  |
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|  |  |  |
| *Parent/guardian/adult student Signature* |  | *Date* |

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