Plainville Community Schools
One Central Square
Plainville, CT 06062
(860) 793-3210 Fax: (860) 747-6790

Authorization for Transfer of Confidential Student Information and Release of Protected Health Information

This form must be completed by student's parents, guardians, or persons with whom the student legally resides.

Child/Patient Full Name: _____ DOB: _____/_____/_____
Address:_____ Phone: _____
School Currently Attending: _____

Student Records

Pursuant to the Family Educational Rights and Privacy Act (**FERPA**), I hearby authorize Plainville Community Schools to release and/or obtain the following confidential records:

	Obtain	Release
All Records	☐	☐
Cumulative File	☐	☐
Pupil Personnel/Special Education Files	☐	☐
Student Success Plans	☐	☐
Other: _____	☐	☐

Records to be Shared With:
Name: _____
Agency: _____
Address: _____
_____
Contact Number: _(_____)_____

Signature: _____ **Signature:** _____ **Date:** _____
(Please Print)

Complete the following section only if records are to be shared with a medical provider.

Medical Records

I authorize any member of the medical staff of _____ to use and/or disclose the protected health
(Physician or Medical Facility)
information of my child, _____, as provided below to Plainville Community Schools. I understand
(Patient Name)
that I may revoke this Authorization, except to the extent that the entity has already taken action in reliance on this Authorization. I understand that I may revoke this Authorization in writing to _____at any time. A provision of
(Physician or Medical Facility)
treatment will not be conditioned on the completion of this Authorization. I understand that once the selected information below is used or disclosed as set forth in this Authorization, such information is subject to re-disclosure and may no longer be protected by the Heath Insurance Portability and Accountability Act of 1996 (**HIPAA**). I understand that any information received by the school pursuant to this authorization is subject to all applicable state and federal confidentiality laws governing further use and disclosure of such information.

Information to Be Used/Disclosed:

- ☐ Complete Medical Record
- ☐ Inpatient Medical Records
- ☐ Outpatient Medical Records
- ☐ Mental Health Psychiatric Records
- ☐ On-going Consultation with Medical Provider
- ☐ Other: _____

Unless I revoke this Authorization in writing or provide a different expiration date below, this Authorization will be valid for a period of twelve (12) months from the date of execution: Other Expiration Date: _____

Signature: _____ **Signature:** _____ **Date:** _____
(Please Print)