



BOARD OF EDUCATION CHAIR
Christi Haskell

SUPERINTENDENT OF SCHOOLS
Paul Brenton
(860)564-6404

Authorization for Release of Information

Student Name: _____ Date of Birth: _____

I hereby authorize the Plainfield Public Schools to release/disclose/obtain _____'s confidential education records/health information to/from the following: _____ child's name

Name: _____
Address: _____
Phone: _____

The information to be disclosed is:

- Cumulative Educational Records
- Special Education/Section 504
- Discipline
- Assessment and Evaluation (Psychological, Speech/Language, OT, PT, Psychiatric, Discharge/Termination Summaries, Diagnostic Information, Social History)
- Pre-Referral Information
- Medical
- Other: _____

The information will be shared orally, in written form, and/or electronically.

The purpose (s) for disclosure is:

- Educational purposes and program planning
- Health care treatment and services
- Other: _____

Authorization

I give my permission to the release of information. I understand authorizing the use or disclosure of the information identified above is voluntary, and I do not need to sign this form to ensure services. This authorization is valid for 24 months. It will expire on _____. I understand that I may revoke this authorization at any time by submitting written notice of the withdrawal of my consent. I recognize that these records, once received by the school district will become education records protected by the Family Educational Rights and Privacy Act. The confidentiality of my record is protected by Federal Confidentiality Regulations 42 CFR (Part 2) and Chapter 899 of the Connecticut General Statutes.

I do not give my permission to the release of information.

Parent/Legal Guardian Signature Date

printed name

Student Signature (if student is 18 years or older) Date

printed name