OFFICE OF PUPIL SERVICES

Regional School District No. 17

57 LITTLE CITY ROAD
HIGGANUM, CONNECTICUT 06441
TEL: (860) 345-4244 / FAX (860) 345-3051

AUTHORIZATION FOR RELEASE OF INFORMATION TO/FROM REGIONAL SCHOOL DISTRICT #17 PUPIL SERVICES

I hereby grant permission for the exchange of information regarding my child:

_____ _____
Student's name Student's date of birth

between Regional School District #17 and:

_____
Name of person

_____
Name of agency

_____
Street address

_____
City, State, Zip

This authorization applies to the following information:

☐ Educational ☐ Medical ☐ 504 ☐ SRBI/RTI ☐ Confidential File

Other: _____

_____ _____
Signature Date

_____ _____
Printed Name Relationship

DURATION:

This authorization shall become effective immediately and shall remain in effect until _____ (enter date) or for one year from the date of signature, if no date entered.

RESTRICTIONS:

Law prohibits the Requestor from making further disclosure of my health/education information unless the requester obtains another authorization form from me or unless such disclosure is specifically required or permitted by law.

YOUR RIGHTS:

I understand that I have the following rights with respect to this Authorization: I may revoke this Authorization at any time. My revocation must be in writing, signed by me or on my behalf, and delivered to the persons on the front. My revocation will be effective upon receipt, but will not be effective to the extent that the Requestor or others have acted in reliance to this Authorization.

RE-DISCLOSURE:

I understand that the Requestor (School District) will protect this information as prescribed by the Family Educational Rights and Privacy Act (FERPA) and that the information becomes part of the student's educational record. The information will be shared with individuals working at or with the School District for the purpose of providing safe, appropriate, and least restrictive educational settings and school health services and programs.

I have a right to receive a copy of this Authorization. Signing this Authorization may be required in order for this student to obtain appropriate services in the educational setting.

APPROVAL:

_____	_____	_____
Printed Name	Signature	Date
_____	_____	
Relationship to Patient	Area Code and Telephone Number	