STONINGTON PUBLIC SCHOOLS

40 FIELD STREET, PAWCATUCK, CT 06379
PHONE: (860) 572-0506 **FAX: (860) 572-1470**
Special Services FAX: 860-599-0233

TRANSFER OF CONFIDENTIAL STUDENT INFORMATION
PROTECTED HEALTH INFORMATION

_____
Date

Name of Child: _____ **DOB:** _____

Address: _____ **Town/State/Zip Code:** _____

Parent(s)/Guardians(s): _____ **School:** _____

	Obtain	**Release**
Health/Medical *	☒	☒
Other (please specify): Verbal	☒	☒

To/From: _____
Name

Address: _____ _____ _____
Street Town State/Zip Code

Telephone: _____ Fax: _____

* If this authorization is being used to obtain Protected Health Information from a child's physician or other covered entity under HIPPA, the following section must also be completed:

I, the undersigned, specifically authorize _____ to disclose my child's medical
Name of Physician

Stonington Public Schools
Name of School
at the above address for the purposes described below (i.e., health assessment for school entry, special education evaluation, etc.):

By signing below, I agree that a photocopy of this authorization will be valid as the original. This authorization will be valid for a period of one year from the date below. I understand that I may revoke this authorization at any time by notifying the physician's office in writing, but if I do, it will not have any effect on actions taken prior by the Physician prior to receiving such revocation.

I understand that under applicable law, the information disclosed under this authorization may be subject to further disclosure by the recipient and thus, may no longer be protected by federal privacy regulations.

I understand that my child's treatment or continued treatment with any health care provider or enrollment or eligibility for benefits with any health plan may not be conditioned upon whether or not I sign this authorization and that I may refuse to sign it.

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.

_____ _____
Signature of Parent/Guardian Date

_____
Print Name of Parent/Guardian