

# STONINGTON PUBLIC SCHOOLS

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DIRECTOR OF FINANCE  
Gary J. Shettle

## TRANSFER OF CONFIDENTIAL STUDENT INFORMATION FAMILY EDUCATIONAL RIGHTS AND PRIVACY ACT (FERPA)

\_\_\_\_\_  
Date

Pursuant to the Family Educational Rights and Privacy Act ("FERPA"), I hereby authorize the Stonington Public Schools to **release** and/or **obtain** (please circle) the following confidential records regarding my child:

Name of Child: \_\_\_\_\_ DOB: \_\_\_\_\_

Address: \_\_\_\_\_ Town/State/Zip Code: \_\_\_\_\_

Parent(s)/Guardians(s): \_\_\_\_\_ School: \_\_\_\_\_

(Please check all that apply.)

Obtain

Release

All records

Cumulative File

Pupil Personnel/Special Education

Disciplinary

Health/Medical \*

Other (please specify):

Verbal: \_\_\_\_\_

\* If this authorization is being used to obtain Protected Health Information from a child's physician or other covered entity under HIPPA, a Transfer of Confidential Information – Protected Health Information form must also be completed.

To/From: \_\_\_\_\_

Address: \_\_\_\_\_  
Street Town State/Zip Code

Telephone: \_\_\_\_\_ Fax: \_\_\_\_\_

I understand that the information to be disclosed is protected as an "education record" under FERPA, and that such information shall not be redisclosed unless permitted under FERPA. I further understand that the officers, employees, and agents of any party that receives protected information under FERPA may use such information only for purposes for which the disclosure is made.

\_\_\_\_\_  
Signature of Parent/Guardian

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print Name of Parent/Guardian