New/Transfer Student Record Release Form

Student Name:	Date of Birth:	Grade:

Previous School Name:
School address (number and street name):
City:
State:
Phone Number:

Region 15 is requesting the following:

	Cumulative File (Complete) ● School transcripts, including earned credits if applicable ● All available report cards ● All available district and state assessment scores ● Other: _____	
	Health/Medical Records* (please see next page)	
	Regular/Special Education Records, include as available ● All available IEPs/504s ● Most recent PPT Minutes ● Consents for pending evaluations ● Psychological/Psychoeducational Evaluations ● Academic Evaluations	● Psychiatric/Neuropsychological/Outside Provider Evaluations ● Speech/Hearing/Audiological/Language Evaluations ● Social Work Assessments ● SRBI Data ● Other: _____

Please release the above information to (by mail, fax or email):

Mail: Region 15 Board of Education Office/Registration
P.O. Box 395, 286 Whittemore Road
Middlebury, CT 06762-0395
Fax: (203) 758-2776
Email to: Registration@Region15.org

Contact Person:
Registration Department
Phone: (203) 758-8259 extension 1023

Date Sent: _____

According to the Family Education Rights and Privacy Act (Buckley Amendment) June 17, 1976, it is no longer necessary to obtain written consent to release records. School officials, including teachers within the educational institution and officials of other schools in school systems in which the student may intend to enroll, may receive a student's record without written consent for such release.

Student Medical/Educational Information Release Form

(Student Name) (Student DOB) (Grade)

(Student Street Address) (Town/State/Zip)

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

I, the undersigned, specifically authorize

(Name of Physician/Provider)

(Physician/Provider Street Address)

(Physician/Provider Phone)

to obtain, disclose, and discuss my child's medical information, as specified above, to Pomperaug Regional School District 15 Board of Education Office/Registration (P.O. Box 395, 286 Whittemore Road, Middlebury, CT 06762-0395) for the purposes described below:

- Health/Medical Information
- Special education evaluation
- Consultation with mental/medical health providers

* * * * * *

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 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 district 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