

**KILLINGLY INTERMEDIATE
SCHOOL**

1599 Upper Maple Street
Dayville, CT 06241
Fax: 860-779-9639

**KILLINGLY
PUBLIC
SCHOOLS**



Great Things Happen Here!

**KILLINGLY HIGH
SCHOOL**

226 Putnam Pike
Dayville, CT 06241
Fax: 860-774-0846

***CONSENT TO REFER TO CHR FOR SERVICES IN SCHOOL*
AUTHORIZATION TO OBTAIN/RELEASE INFORMATION**

PURPOSE: As a parent, guardian or student, you have the right to give permission or not give permission for the release of your child's records with other persons or agencies. This request provides you with the opportunity to approve or not approve such a request unless release of records is allowed under one of the exceptions under the rules implementing the Family Education Rights and Privacy Act, FERPA, (for example, transfer of records from one school district to another).

NAME OF STUDENT

D.O.B.

SCHOOL

☐ Medical Health Records

☐ Attendance Records

☐ Discipline/Suspension Records

☐ Academic Records/Current grades/Cumulative Folder

☐ Special Education Records (including evaluations, PPT records,
IEP/504 plan)

☐ Any other Pertinent Information

I hereby authorize staff of Killingly Public Schools to release/obtain all records, indicated above, concerning my child/children to staff of CHR, for the purposes of referral for school-based services, and to assist in educational planning, service planning, service provision, and/or service coordination. My signature below indicates my consent for Killingly Public Schools' staff to make a referral for behavioral health services during the school day, provided by CHR, on my child's behalf.

I understand that this information obtained will be treated in a confidential manner by the school district under the provisions of the Family Education Rights and Privacy Act (FERPA). FERPA prohibits disclosure of personally identifiable information without consent except in limited circumstances. Please note that if the request is for health or medical information, the medical information received by the district is protected under FERPA privacy standards and not the Health Insurance Portability and Accountability Act (HIPAA).

This authorization is valid for one year from: _____ to _____.
Date **Date**

I understand that my consent for the referral to CHR and the authorization to release/obtain records is voluntary and I can withdraw my consent at any time in writing. Should I withdraw my consent, it does not apply to information that has already been provided under the prior consent for release.

Parent/Legal Guardian Signature

Date

Authorized School Official Signature

Date

Parent/Legal Guardian Printed Name

Authorized School Official Printed Name