

BRISTOL WARREN REGIONAL SCHOOL DISTRICT

Administrative Office
50 Asylum Road
Warren, RI 02885

RELEASE OF INFORMATION FORM

Student Name:			
Student's Date of Birth:		School:	
The Bristol Warren Regional School District is authorized to: (Check <u>ONE</u> box <i>ONLY</i>)			
☐ OBTAIN FROM		☐ RELEASE TO	
Agency/ Person		Telephone:	
Address:		Fax:	
		Email	
Verbal Exchange: ☐ YES ☐ NO			

Records to be released or disclosed:

☐ Adaptive Physical Education	☐ Occupational Therapy	☐ Speech and Language
☐ Educational	☐ Functional Behavior Assessment	☐ Vocational
☐ Psychological	☐ Physical Therapy	☐ Other:
☐ IEP	☐ Clinical Psych/Psychiatric	☐ Other:
☐ Medical	☐ Social History	☐ Other:

Purpose of the release/disclosure:

☐ Assist in educational planning	☐ Transfer to a new school district
☐ Share evaluation/re-evaluation results	☐ Transition Planning
☐ Parent/Guardian Request	☐ Other:

Within the educational setting, the Family Educational Rights and Privacy Act (FERPA) governs the confidentiality and disclosure of educational records. This form is used to request the release of information to assist in providing educational programs and services to the named student. It also permits the Bristol Warren Regional School District's individual/organization listed above. Any confidential student information received by the District and maintained or kept will become part of the student's educational record.

This consent will have a duration of no longer than one (1) year from the date of this form. I understand that I may withdraw my consent in writing at any time. I understand that a withdrawal will not apply to information already released in response to this authorization. I understand that authorizing the disclosure of health information is voluntary. I can refuse to sign the authorization. I understand that I may inspect or obtain information to be used or disclosed as provided in CFR 164.524. I understand that any disclosure of information carries with it a potential for an unauthorized re-disclosure and the information may not be protected by confidentiality rules.

I have read and understand the above statements and do herein voluntarily consent to disclosure of the above information and/or mental health records to the persons/agencies named above.

Signature of Parent/Guardian/Adult Student: _____ Date: _____

*Parent/Guardian authorization is not required to transfer educational records to another school district.