Litchfield Public Schools - Release of Information

Center School	Intermediate School	Middle/High School	Director of Special Services
125 West Street	35 Plumb Hill Road	14 Plumb Hill Road	35 Plumb Hill Road
P.O. Box 110	P.O. Box 110	P.O. Box 110	P.O. Box 110
(860) 567-7510	(860) 567-7520	(860) 567-7540/7530	(860) 567-7505
Fax: (860) 567-7518	Fax: (860) 567-7528	Fax: (860) 567-7538	Fax: (860) 567-7508
Grades PK-3	Grades 4-6	Grades 7-12	

To: _____
(Name) (School/Facility) (Title/Dept)

_____
(Address) (Phone) (Fax)

From: _____
(Name) (Address) (Phone)

Student's Name:_____ **DOB**_____

_____ Please forward to us, at your earliest convenience, the records checked below.

_____ Enclosed are records that were requested to be sent to you.

_____ Complete record
_____ Transcript and cumulative records
_____ Health records
_____ Speech/Lang. Evaluation
_____ Special Education Records (IEP's, PPT minutes, Individual Educational Testing)
_____ Other, as specified_____
_____ School Observation
_____ Attendance records
_____ Disciplinary records
_____ Verbal Communication

_____ I give permission for the above information to be released to the Litchfield Public Schools.

_____ I give permission for the Litchfield Public Schools to transmit this information to person/school named above.

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

This authorization is valid for one calendar year. It will expire on _____. I understand that I may revoke this authorization at any time by submitting written notice of the withdrawal of my consent to the school/program administrator. I recognize that education records are protected by the Family Educational Rights and Privacy Act and that I can request information regarding my rights under Family Educational Rights and Privacy Act from Litchfield Public Schools.

This material shall not be transmitted to anyone without written consent or other authorization as provided in the aforementioned statues. I recognize that these records, once received by the school district, may not be protected by the HIPAA Privacy Rule, but that they will become education records protected by the Family Educational Rights and Privacy Act (FERPA). I also understand that if I refuse to sign, such refusal will not interfere with my child's ability to obtain health care.
**If a minor student is authorized to consent to health care without parental consent under federal or state law, only the student shall sign this authorization form. In Connecticut, a competent minor, depending on age, can consent to outpatient mental health care, alcohol and drug abuse treatment, testing for HIV/AIDS, and reproductive health care services.

cc: Student File
Parent/Guardian or eligible student
Agency/consultant releasing the educational information
School official requesting/receiving the protected information