TRANSFER OF CONFIDENTIAL STUDENT INFORMATION

Date: _____

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

Name of Child: _____
Address: _____
_____
_____
_____
DOB: _____

Parent(s)/Guardian(s):_____
School: _____

(Please check all that apply)

	Obtain	Release
All Records	□	□
Cumulative File	□	□
Pupil Personnel/Special Education	□	□
Disciplinary	□	□
Health/Medical*	□	□
Other (please specify)	□	□

	Obtain	Release
Other:		
_____	□	□
_____	□	□
_____	□	□
_____	□	□

To/From: _____
Name

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

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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 _____ to disclose my child's
Name of Physician

medical information, as specified above, to my child's school, _____,
Name of School

at the above address for the purposes described below (i.e. health assessment for school entry, special education evaluation etc.):

_____

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 school pursuant to this authorization is subject to all applicable state and federal confidentiality laws governing further use and disclosure of such information.

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_____ _____

Signature of Parent/Guardian Date

_____

Print Name of Parent/Guardian

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