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| **STONINGTON** PUBLIC SCHOOLS  **49 North Stonington Road · P.O. Box 479 · Old Mystic, CT 06372**  **Phone: (860) 572-0506 Fax: (860) 572-1470**  **BOARD OF EDUCATION: Frank Todisco, Chairperson; Deborah Downie, Secretary** | | | | | | | | | | | | | | | | | | |  |
|  | | | | | | | | | | | | | | | | | | |  |
| **SUPERINTENDENT** | | | | **ASSISTANT SUPERINTENDENT** | | | | **DIRECTOR OF SPECIAL SERVICES** | | | | | | | | | | | **BUSINESS MANAGER** |
| Van W. Riley, Ph.D. | | | | Nikki Gullickson | | | | Allison Van Etten | | | | | | | | | | | William King |
|  | | | | | | | | | | | | | | | | | | | |
| **TRANSFER OF CONFIDENTIAL STUDENT INFORMATION** | | | | | | | | | | | | | | | | | | | |
| **FAMILY EDUCATIONAL RIGHTS AND PRIVACY ACT (FERPA)** | | | | | | | | | | | | | | | | | | | |
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| Date | | | | | |  | | | | | | | | | | | | | |
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| Pursuant to the Family Educational Rights and Privacy Act (“FERPA”), I hereby authorize the Stonington Public Schools to **release** and/or **obtain** (please circle) the following confidential records regarding my child: | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | |
| **Name of Child:** | | |  | | | | | | | | | | | | **DOB:** | | |  | |
|  | | | | |  | | | | | | | | | | | | | | |
| **Address:** |  | | | | | | | | **Town/State/Zip Code:** | | | | |  | | | | | |
|  | | | | |  | | | | | | | | | | | | | | |
| **Parent(s)/Guardians(s):** | | | | |  | | | | | | | | **School:** |  | | | | | |
|  | | | | | | | | | | | | | | | | | | | |
| **(Please check all that apply.)** | | | | | | | **Obtain** | | | | **Release** | | |  | | | | | |
|  | | | | | | |  | | | |  | | |  | | | | | |
| All records | | | | | | |  | | | |  | | |  | | | | | |
| Cumulative File | | | | | | |  | | | |  | | |  | | | | | |
| Pupil Personnel/Special Education | | | | | | |  | | | |  | | |  | | | | | |
| Disciplinary | | | | | | |  | | | |  | | |  | | | | | |
| Health/Medical **\*** | | | | | | |  | | | |  | | |  | | | | | |
| Other (please specify): | | | | | | |  | | | |  | | |  | | | | | |
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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 HIPPA, a Transfer of Confidential Information – Protected Health Information form must also be completed. | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | |
| 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. | | | | | | | | | | | | | | | | | | | |
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|  | | | | | | | |  | | | | | |  | | | | | |
| Signature of Parent/Guardian | | | | | | | |  | | | | | | Date | | | | | |
|  | | | | | | | |  | | | | | |  | | | | | |
| Print Name of Parent/Guardian | | | | | | | |  | | | | | | Form Date: 2/19/2014 | | | | | |