

STONINGTON PUBLIC SCHOOLS

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TRANSFER OF CONFIDENTIAL STUDENT INFORMATION PROTECTED HEALTH INFORMATION

Date

Name of Child: _____ DOB: _____

Address: _____ Town/State/Zip Code: _____

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

Obtain

Release

Health/Medical *



Other (please specify):

Verbal



To/From:

Name

Address:

Street

Town

State/Zip Code

Telephone:

Fax:

* If this authorization is being used to obtain Protected Health Information from a child's physician or other covered entity under HIPPA, the following section must also be completed:

I, the undersigned, specifically authorize _____ to disclose my child's medical
_____ at the above address
Name of School

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 prior 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.

Signature of Parent/Guardian

Date

Print Name of Parent/Guardian

Form Update: 11/18/2021