Putnam Public Schools

Release of Records

Student Name: ______________________________ **Grade:** ____________________ **Date of Birth**: ______________

I hereby authorize Putnam School Officials at:
□ Putnam Elementary School, 33 Wicker Street, Putnam, CT 06260 – 860-963-6925 or fax 860-963-6931
□ Putnam Middle School, 35 Wicker Street, Putnam, CT 06260 – 860-963-6920 or fax 860-963-6921
□ Putnam High School, 152 Woodstock Avenue, Putnam, CT 06260 – 860-963-6905 or fax 860-963-6911
to exchange health and education information/records for the purpose(s) listed below with:

______________________________________ ______________________________
School/Agency Name School/Agency Official

______________________________________ ______________ ______________
School/Agency Address phone # fax #

Description:
The health information to be disclosed consists of:
All school health records to facilitate school entry.

The education information to be disclosed consists of:
All educational records (include Educational, ELL, Psychological, Psychiatric, Speech/Related Services Evaluations) to facilitate school entry. Please send all **special education records** to: ***Special Education Department, Putnam Board of Education, 35 Wicker Street, Putnam, CT 06260***

Purpose: This information will be used for the following purpose(s):
1. Educational evaluation and program planning
2. All educational assessment results
3. Health assessment and planning for health care services and treatment in school
4. Medical evaluation and treatment
5. Other:____

Authorization

This authorization is valid for one calendar year from the date of signature below. I understand that I may revoke this authorization at any time by submitting written notice of the withdrawal of my consent. I recognize that health records, once received by the school district, may not be protected by the HIPAA Privacy Rule, but will become education records protected by the Family Educational Rights and Privacy Act. I also understand that if I refuse to sign, such refusal will not interfere with my child's ability to obtain health care. I agree that a copy of this authorization is as valid as the original.

____
Parent/Guardian Signature Date

____
Student Signature* Date

*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.

Copies: Parent or student*
Physician or other health care provider releasing the protected health information
School official requesting/receiving the protected health information Rev. 7/15/19