

**Groton Public Schools  
Pupil Personnel Services  
1300 Flanders Road  
Mystic, CT 06355  
(860) 572-2155 FAX (860) 572-2107**

**HIPAA-Compliant Authorization for Exchange of Health & Education Information**

**Student/Patient Name:** \_\_\_\_\_ **Date of Birth:** \_\_\_\_\_

I hereby authorize Eileen Cicchese, Groton Parks and Rec and Denise Doolittle, Groton Public Schools  
(School Official/Health Care Provider Name & Title) (Groton Public School Official Name & Title)

Eileen Cicchese: Groton Parks and Recreation 27 Spicer Ave. Noank, CT 06340. (860)536-5680  
(School/Health Care Facility Name, Address and Telephone)

Denise Doolittle: Groton Public Schools, 1300 Flanders Road, PO Box K Groton, CT 06340. (860)572-2152  
(Groton Public School Name Address & Telephone)

To exchange health and education information/records for the purpose listed below.

Please check all that apply	<u>Obtain</u>	<u>Release</u>
<b>All Records</b>	( )	( )
<b>Cumulative File</b>	( )	( )
<b>Pupil Personnel/Special Education</b>	( )	( )
<b>Disciplinary</b>	( )	( )
<b>Health/Medical</b>	( )	( )
<b>Other (please specify) ___ Behavior Intervention Plan, Verbal Communication ___</b>	( X )	( X )

**Purpose: This information will be used for the following purpose(s):**

1. Educational evaluation and program planning
2. Health assessment and planning for health care services and treatment in school.
3. Medical evaluation and treatment
4. Other \_\_\_\_\_  
\_\_\_\_\_

**Authorization**

This authorization is valid for one calendar year. It will expire on 3/20/19 (Date). 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.

\_\_\_\_\_  
(Parent 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.

**This information is for the confidential use of the above-named personnel only who are directly involved in helping your child. The Family Educational Rights and Privacy Act (FERPA) the (BUCKLEY AMENDMENT) authorizes local districts to forward school records, without the permission of the parent or student over the age of 18 to school officials where student may intend to enroll upon the condition that the student or parent be notified.**