Student Record Release Form

Student Name:	Date of Birth:

Previous School (number and street name):
City:
State:
Phone Number:

Region 15 is requesting the following:

	Cumulative File
	School Transcripts (grades, test scores, including earned credits, etc.)
	Health/Medical* (please see next page)
	Special Education Records & Release Records (IEP, PPT Minutes, Psychological, Speech/Hearing Evaluations, Social Work)

Please release the above information to (by mail, fax or email):

Mail: Region 15 Board of Education Office/Registration
P.O. Box 395, 286 Whittemore Road
Middlebury, CT 06762-0395
Fax: (203) 758-2776
Email to: registration@region15.org

Contact Person:
Kelly Zablauskas
PowerSchool Admin/Registrar
Phone: (203) 758-8259 extension 123

Date Sent: _____

According to the Family Education Rights and Privacy Act (Buckley Amendment) June 17, 1976, it is no longer necessary to obtain written consent to release records. School officials, including teachers within the education institution and officials of other schools in school systems in which the student may intend to enroll, may receive a student's record without a written consent for such release.

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Health/Medical*:
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
(Name of Physician)
child's medical information, as specified above, to Pomperaug Regional School District 15 Board of Education Office/Registration (P.O. Box 395, 286 Whittemore Road, Middlebury, CT 06762-0395) for the purposed 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 district 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