Southwest Vermont Supervisory Union

184 North Street Suite 1, Bennington, VT 05201

Telephone: 802-447-7501

DISCLOSURE OF STUDENT/PATIENT EDUCATION AND HEALTH RECORDS AND INFORMATION

I give permission to _____ and _____ [name of hospital, medical practice, or similar organization], to release medical records and information about my son/daughter _____ DOB _____ (including information subject to the Health Insurance Portability and Accountability Act -HIPAA - protections), to the Southwest Vermont Supervisory Union, and their employees and agents, specifically _____ (name of staff and/or school nurse) for the purpose of coordination of services to support educational planning, (including but not limited to regular and special education and related services, accommodations, placement decisions, and school-related activities) for my child.

I also give permission to the Southwest Vermont Supervisory Union, and their agents and employees, to release my child's education records and information contained therein (including such information protected by the Family Educational Rights and Privacy Act (FERPA)), to their named provider above and personnel working with said provider in my child's case, for the sole purpose of consulting with them about my child's health condition(s) and the effects on their ability to participate in learning and other school-related activities.

I understand that any education and health records disclosed for these purposes may be redisclosed and will then no longer be protected by HIPAA's privacy rule.

This consent to release and exchange of information is provided on condition that neither party will disclose any such information to any other party without my prior consent except as allowed by law, and that I will be provided with copies of any records provided by either party to the other. This consent is effective for one year from the date it is signed and may be revoked by notifying either party in writing.

_____ _____

Parent/Guardian **Date**