DISTRICT OFFICES
Tom Flanagan, Superintendent
150 Colchester Avenue
Burlington, VT 05401
802-865-5332
superintendent@bsdvt.org

Authorization to Release/Exchange Confidential Information

Student Name: _____ School: _____ DOB: _____

I hereby authorize Burlington School District to exchange information (**two-way**) on the student listed above with a person, school, organization, or agency as indicated below:

Name: Phone: Email:	Organization/Agency: Physical Address:

Name: Phone: Email:	Organization/Agency: Physical Address:

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Name: Phone: Email:	Organization/Agency: Physical Address:

Name: Phone: Email:	Organization/Agency: Physical Address:

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

Please check the records to be shared:	
☐ Psychological Reports ☐ Social Work Reports ☐ Psychiatric Reports ☐ Medical/Hospital Records/Reports ☐ Educational Records/Reports	☐ Evaluations, IEPs, 504s, Progress Notes ☐ Telephone Contacts ☐ Email Contacts ☐ Observation Notes
☐ Other:	

This information will be used for the following purposes:

- Evaluative and educational program planning
- Health assessment and planning to ensure safe health care services and treatment in school
- Medical evaluation and treatment
- Other: _____

This authorization is valid for one calendar year. It will expire _____. 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/Guardian Signature*] [*Date*]

_____

[*Student Signature, if applicable**] [*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 Vermont, 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.*