Barnstead Elementary School, SAU 72
91 Maple Street
Barnstead, NEW HAMPSHIRE 03225

PARENTAL CONSENT FOR RELEASE OF RECORDS AND EXCHANGE OF INFORMATION

The School District is required to obtain written consent from the parent before personally identifiable information from a student's education record is disclosed to any party other than those who are permitted access by law. Consent is also required before personally identifiable information is used for any other purpose than to aid in the planning for and provision of appropriate educational services to the student.

Student: _____ **DOB:** _____ **Address:**

_____ **I hereby**

authorize the release and exchange of protected health information to/from:

RECORDS OR INFORMATION TO BE DISCLOSED BY/TO:

(Please enter the doctor's information below)

Name:_____

Mailing Address: _____

_____

Phone:_____

Fax:_____

RECORDS OR INFORMATION TO BE DISCLOSED BY/TO:

Name: BES Health Office

Mailing Address:

91 Maple St, Barnstead NH 03225

Phone: 603-269-5161

Fax: 603-269-2632

Regarding: ( ) Allergy Care Plan ( ) Asthma Care Plan ( ) Physical ( ) Immunizations ( ) Other

_____

The reason for this disclosure is: (please check one)

_____Planning Education Program _____ Required Documentation for Child's Health Record

This consent is in effect for one calendar year. 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 HIPPA 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.

A copy of the records to be released will be provided to you upon request. Thank you.

Parent/Guardian Signature:_____ **Printed**

Name:_____ **Date:**_____