NORTH PROVIDENCE SCHOOL DEPARTMENT

Special Education Department
2240 Mineral Spring Avenue
North Providence, RI 02911
Phone: (401) 830-5676 Fax: (401) 231-8486

RELEASE OF CONFIDENTIAL INFORMATION

DATE:	STUDENT:	DATE OF BIRTH:
ADDRESS:		TELEPHONE:

SCHOOL: GRADE:

I HEREBY AUTHORIZE AND REQUEST THAT THE NORTH PROVIDENCE SCHOOL DEPARTMENT: ☐ RELEASE TO:
☐ EXCHANGE WITH: ☐ OBTAIN FROM: ☐ VERBAL EXCHANGE WITH: ☐ CONDUCT OBSERVATION AT:

	AGENCY/SCHOOL/INDIVIDUAL	

Phone: Fax: Email:

THE FOLLOWING INFORMATION REGARDING MY CHILD:

☐ Academic records	☐ Educational	☐ Social history	☐ Child Outcomes Summary Forms
☐ Medical/Health	☐ Psychological	☐ Clinical/Psychiatric	☐ Teacher/Therapist Notes & Observations
☐ I.E.P. ☐ 504 Plan ☐ IFSP	☐ Speech/Language	☐ Meeting minutes	☐ Neuropsychological/Neurodevelopmental
☐ Eligibility Determination Form	☐ Occupational Therapy	☐ Physical Therapy	☐ Audiological

☐ OTHER: _____

FOR THE PURPOSE OF: ☐ Educational Planning ☐ Other: _____

Medical/Health information is protected under R.I. Gen. Laws §5-37.3-4 (as amended from time to time). Except as provided by law, the information released with this authorization will not be given, sold, or in anyway relayed to any other person not specified in this release form. Educational records are covered under the Family and Educational Rights and Privacy Act (FERPA) and, under most circumstances, require this signed Authorization prior to their release. The Consent for release or transfer of information may be withdrawn at any future time. To the extant that the information to be released by virtue of this Authorization constitutes Protected Health Information (PHI) and is covered under the Health Insurance Portability and Accountability Act (HIPAA), you have the right to revoke this authorization unless the school department has already taken action in reliance upon it. The revocation must be in writing, and received by the Office of the Superintendent of Schools, 2240 Mineral Spring Avenue, North Providence, RI, 02911. The PHI used or disclosed pursuant to this Authorization may be suspect to redisclosure by the recipient and may no longer be protected by HIPAA's privacy rules. Generally, a school department may not condition treatment, payment, enrollment, or benefits eligibility upon receiving this Authorization. However, if this Authorization involves information which may be necessary to determine eligibility or the need for certain services pursuant to state and federal law, then refusal to execute this Authorization may result in a delay or denial of eligibility or receipt of services.

This release is valid through_____ unless permission is withdrawn sooner, in writing, by the undersigned.

Signature: _____ Relationship: _____ Date: _____

Printed Name: _____ Witness: _____

Signature of Student if 18 years or older: _____