Policy #5125 – Form #5

WINCHESTER PUBLIC SCHOOLS

Winsted, Connecticut 06098

RELEASE OF CONFIDENTIAL HIV-RELATED INFORMATION

I hereby authorize _____ to release

[name of individual who holds the information] _____

confidential HIV-related information, as defined in Connecticut General Statute §19a-581, concerning _____ to the following personnel:

_____
[name of protected individual]

1. School Nurse
2. School Administrator(s)
   a._____
   b._____
3. Student's Teacher(s)
   a._____
   b._____
4. Paraprofessional(s)
5. Director of Pupil Personnel Services
6. Other(s)
   a._____

b._____

This authorization shall be valid for:

1. ☐The student's stay at _____ School

2. ☐The current school year

3. ☐Other _____ (specify period)

I provide this information based on my responsibility to consent for the health care of _____. I understand that such information shall be held confidential by the persons authorized here to receive such information, except as otherwise provided by law.

_____
Name

_____
Relationship to Student

_____
Date