***To be translated into the student's home language***

**INFORMED CONSENT AND RELEASE FOR PROVISION OF MEDICAL INFORMATION TO THE CAMBRIDGE PUBLIC SCHOOLS**

I, _____, acknowledge that my child, _____,
(Print Name of Parent/Guardian/Caregiver) (Print Child's Name)

been treated at the _____ (hereinafter defined as "Healthcare Facility").
(Insert Name of Healthcare Facility)

I acknowledge that my child went to this Healthcare Facility on or about _____.
(Insert Date)

In order to facilitate the successful reintegration of my child into the school setting, I give consent for the Healthcare Facility to release my child's medical, health, including discharge plan and other confidential information relating to the counseling and/or treatment of my child at the Healthcare Facility and other Protected Health Information, as that term is defined in 45 C.F.R. §264.502 and the Privacy Rule of the Health Insurance Portability and Accountability Act, relating to the counseling and/or treatment of my child, to the Cambridge Public Schools. I also hereby give consent for staff from the Cambridge Public Schools to participate in and/or have discussions and/or meetings with staff of the Healthcare Facility regarding the discharge plan for my child and regarding any other confidential information relating to the counseling and/or treatment of my child at the Healthcare Facility and/or any other Protected Health Information regarding my child that is released to the Cambridge Public Schools.

I have read this Informed Consent and Release for Provision of Medical Information to the Cambridge Public Schools and understand its terms. I sign it voluntarily and with full knowledge of its significance.

_____ _____
Parent/Guardian/Caregiver's Signature Date