BORINQUEN
MEDICAL CENTERS

Patient Name ______________________________ MR#____________________

Parental consent to Share Educational Information to Health Care Provider

The family Educational Rights and Privacy Act (FERPA) is a Federal law that prohibits schools from disclosing information about your child to anyone outside the school system without permission of the student's parent. As part of your child's health care, his or her doctor and/or doctor's assistants are requesting to receive information from Miami-Dade County Public Schools (M-DCPS) concerning his or her attendance information about your child's progress in school can assist with complete health care and the educational success of your child.

Only medical personnel authorized to see your child's health records would be permitted to see information about your child's school attendance and achievement scores. The medical personnel given permission to review this information would not be allowed to share the information to anyone else and will not have access to any other educational information or records.

If you agree to give permission to your child's medical team (i.e., the employees of the office indicated below) to obtain access to your child's school attendance and test achievement records, please read the sentences below. If you do not consent to release the personally identifiable educational information to your child's medical team, please indicate that your are not providing informed consent to do so. If you choose not to provide consent, your child's medical care will not be affected. You are under no obligation to provide consent.

I understand that I am being asked to provide informed consent to Miami Dade County Public Schools (M-DCPS) to disclose my child's attendance and achievement test records to his or her medical team to ensure there are no preventable health, psychological or social barriers to his or her learning. I understand that federal law prohibits anyone who sees my child's personally identifiable educational records from re-disclosing those records without my permission. I understand that permission may be revoked at any time by submitting a new consent from at my child's medical office.

I hereby certify that I am the parent/legal guardian of the student whose information will be used or disclosed. The child's name is _____________________________ my relation to this child is ______________________. The name and address of my child's medical team is:

Borinquen Medical Centers, 3601 Federal Highway, Miami, FL 33137-3795

- ☐ I **DO** give permission to M-DCPS disclose my child's educational records as described in this document.
- ☐ I **DO NOT** give permission to M-DCPS disclose my child's educational records as described in this document.

__________________________________ __________________________________

Signature Date

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Print Name