



CAMBRIDGE PUBLIC SCHOOLS  
159 THORNDIKE STREET CAMBRIDGE, MASSACHUSETTS 02141

*To be translated into the student's home language*  
**INFORMED CONSENT AND RELEASE  
FOR PROVISION OF MEDICAL INFORMATION TO CPS**

I, \_\_\_\_\_, acknowledge that my child,  
(Print Name of Parent/Legal Guardian)

\_\_\_\_\_ has been treated at the \_\_\_\_\_  
(Print Child's Name) (Insert Name of Health Care Facility)

(hereinafter defined as "Health Care Facility"). I acknowledge that my child went into this Health Care Facility on or about \_\_\_\_\_. In order to facilitate the  
(Insert Date)

successful reintegration of my child into the school setting, I give consent for the Health Care 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 Health Care Facility to the Cambridge Public Schools 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. 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 Health Care Facility regarding the discharge plan for my child.

I have read this Informed Consent and Release for and understand its terms. I sign it voluntarily and with full knowledge of its significance.

\_\_\_\_\_  
Parent/Legal Guardian's Signature

\_\_\_\_\_  
Date