SHERMAN ISD
HEALTH SERVICES DEPARTMENT

CONSENT FOR RELEASE OF CONFIDENTIAL INFORMATION

_____ _____ _____
Student's Name Date of Birth Grade

I authorize the person or agency named below to release records containing confidential information regarding the above-named student to the school staff person named below.

INFORMATION TO BE RELEASED FROM:

_____
Name and Position

_____
Address

_____
City/State/Zip

INFORMATION TO BE RELEASED TO:

_____
Name and Position

_____
School

_____
Telephone Number

PURPOSE OF DISCLOSURE: _____

I have been fully informed and understand the school's request for my consent as described above. This information will be released upon receipt of my written request.

I understand that my consent is voluntary and may be revoked at any time.

This authorization includes all written and verbal communication between the persons/agencies listed above.

_____ _____
PRINT NAME of Parent/Guardian/Surrogate Parent/Adult Student Telephone Number

_____
ADDRESS of Parent/Guardian/Surrogate Parent/Adult Student

_____ _____
SIGN NAME of Parent/Guardian/Surrogate Parent/Adult Student **Date**

Signature of Interpreter if used: _____ Date: _____