SHERMAN ISD
HEALTH SERVICES DEPARTMENT

Date_____

CONSENT FOR RELEASE OF CONFIDENTIAL INFORMATION

Student's Name	Date of Birth	School	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 REALEASED 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.

Signature of Parent/Guardian/Surrogate Parent/Adult Student Date

Address of Parent Telephone

Signature of Interpreter if used