



Health Services

**Consent to Release Confidential Information**

Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Student ID: \_\_\_\_\_  
Campus: \_\_\_\_\_ Grade: \_\_\_\_\_

We are asking that you authorize the person or agency named below to release specified records/information regarding the above-named student.

Records/information to be released to:

Records/information to be obtained from:

\_\_\_\_\_  
Name And Position Of School Staff Person

\_\_\_\_\_  
Agency To Whom The Request Is Made

\_\_\_\_\_  
Name Of ISD

\_\_\_\_\_  
Name Of Person

Address: \_\_\_\_\_  
\_\_\_\_\_

Address: \_\_\_\_\_  
\_\_\_\_\_

Records/information to be released:

\_\_\_\_\_

Purpose of disclosure:

\_\_\_\_\_

\_\_\_\_\_  
Signature of parent, guardian, or adult student

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of interpreter, if used

\_\_\_\_\_  
Date