



Consent to Release Medical Information

Student Name: _____ Student ID Number: _____

Date of Birth: _____ Sex: _____ Grade: _____ Campus: _____

This consent allows the stated MISD Health Service Department and its employees to communicate with the identified Health Care Provider/Institution in order to exchange health care information regarding the student named above. This consent is valid for one school year and must be renewed annually.

MISD requestor: Health Services Department
Campus HSD Staff: _____
Address: _____
City/State/Zip: _____
Phone: _____ Fax: _____

Health Care Provider/Institution: _____
Address: _____
City/State/Zip: _____
Phone: _____ Fax: _____

Permission to obtain:

- On-going communication
- Medical History
- Physician's Orders

___ I have been fully informed and understand the school's request for my consent, as described above.

___ I give permission to MISD to contact me and/or the physician's office as needed.

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

Parent/Guardian Signature

Date

Phone Number

Signature of Interpreter (if appropriate)