Consent to Release Medical Information

Student Name: _____ Student ID Number: _____

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

This consent allows the stated PfISD 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.

PfISD 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:

_X__On-going communication
_X__Medical History
_X__Physician's Orders

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

___I give permission to PfISD 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)