Excellence in Academic Achievement

Carrizo Springs Consolidated Independent School District
452 Hwy 85 East * Carrizo Springs, TX 78834 * Ph (830) 876-3503 Ext 1104

Date sent:

NOTICE FOR RELEASE/CONSENT TO REQUEST CONFIDENTIAL INFORMATION

Name:_____ DOB: _____

School: _____Grade:_____ Student ID: _____

Parent/Guardian:_____ Phone:_____

Home Address:_____

Name of child's Dr. _____
Address of child's Dr. _____
Phone and fax numbers of Dr. _____

Check records to be released/requested	Purpose of disclosure
☐ Treatment Plan Psychological Evaluations Medical Records Notes to School	To assist CSCISD in educational planning and Homebound Services.

Please circle the appropriate responses below.	
Yes No	I have been fully informed and understand the school's request for my consent, as described above. This information will be released/requested upon receipt of my written consent.
Yes No	I understand that my consent is voluntary and may be revoked at any time.
Yes No	I understand that I will be notified in writing of each release of educational related information.

_____ _____
Signature of parent/guardian date

_____ _____
Signature of interpreter if used date

Please return this form to: **Director Human Resource & Student Services**
Micgonzalez@cscisd.net or the school counselor at the assigned campus.

fax: 830-876-9753