



Consent to Release Medical Information

Student Name: _____ Student ID#: _____

DOB: _____ Gender: M | F Grade: _____ Campus: _____

This consent allows the stated PflSD Health Services 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.

Requester: Pflugerville ISD Health Services Department

Campus Health Services Staff: _____

Address: _____

Phone: _____ Fax: _____

Healthcare Provider/ Institution: _____

Address: _____

Phone: _____ Fax: _____

Permission to Obtain:

☐ On- Going Communication

☐ Physician's Orders

☐ Medical History

☐ Immunization Record

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

☐ I give permission to PflSD to contact me and/ or the healthcare provider'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 applicable)