NACOGDOCHES ISD HEALTH SERVICES
CONFIDENTIAL INFORMATION RELEASE

Student Name ______________________________
DOB _______________ Sex ___

Please authorize: _______________________________ (Name)
_______________________________ (Address)
_______________________________ (City,State,Zip)
_______________________________ (Phone)
_______________________________ (FAX)

To Release Confidential Records regarding above name student
______ Medical _____ Psychological _____ Other

FAX To Attention of: ________________________ (School Nurse Name)
________________________ (School Name)
________________________ (FAX #)
________________________ (Phone #)

These records will be used to assist school personnel in determining an appropriate health/medical program for your child.

___ Yes ___ No I have been fully informed and do understand the school's request for my consent for the release of my child's records, as indicated above. This information will be released upon receipt of my written consent.
___Yes ___ No I understand that my consent is voluntary and may be revoked in writing at any time.

Parent/Guardian Signature ___________________________ Date _________________

4/2015