Authorization To Disclose Protected Health Information

Due to state regulations Health Departments and other health entities cannot disclose information without written permission. We will keep this signed permission on file to be used as necessary to obtain health records for your child. Without a signed authorization, a parent will have to go to the health entity to obtain a copy of the record.

Students name:_____ DOB _____

I , _____, authorize:

Physician Name/Health Center _____

Mailing Address_____

City,State,Zip _____

Phone# _____ Fax # _____

To disclose medical information pertinent to school use for Connally ISD. This authorization will stay in effect unless it is revoked by written notification to Connally ISD.

_____ _____

Parent Signature Date