LUBBOCK INDEPENDENT SCHOOL DISTRICT HEALTH SERVICES
CONSENT TO DISCLOSE CONFIDENTIAL INFORMATION

Date Sent/Mailed: _____

☐ **District Disclosure of Information to Third Party**

☐ **Third Party Disclosure of Information to District**

School: _____ **Grade:** _____ **Teacher:** _____

Name: _____ **D-O-B:** _____ **Age:** _____ **Sex:** ☐ **M** ☐ **F**

Parents: _____ **Address:** _____ **Zip:** _____

Telephone (Home): _____ **Telephone (Work):** _____

We are asking that you authorize the District and the Third Party (person or agency) named below to disclose confidential information including specified records containing confidential information regarding the above-named student to each other.

NAME OF SCHOOL NURSE	**NAME AND POSITION OF THIRD PARTY**
Lubbock Independent School District	
NAME OF ISD	**NAME OF THIRD PARTY BUSINESS OR AGENCY**
ADDRESS: _____	**ADDRESS:** _____
_____	_____

INFORMATION/RECORDS TO BE DISCLOSED BY DISTRICT TO THIRD PARTY	PURPOSE OF DISCLOSURE
INFORMATION/RECORDS TO BE DISCLOSED BY THIRD PARTY TO DISTRICT	**PURPOSE OF DISCLOSURE**

Please check (✓) the appropriate boxes below. For more information please call:

_____ at _____

School Nurse **Telephone Number**

YES	NO	
☐	☐	**I have been fully informed and understand the school's request for my consent, as described above. This information will be disclosed upon receipt of my written consent.**
☐	☐	**I understand that my consent is voluntary and may be revoked anytime except that a revocation is not retroactive with respect to any action already taken in reliance on this consent.**

_____ _____

SIGNATURE OF PARENT, GUARDIAN, OR ADULT STUDENT **DATE**

DATE GIVEN: _____ **TO:** _____

NAME

Please return this form to: _____ at: _____ _____

School Nurse **School** **Fax #**