Killeen Independent School District

Consent for Release of Medical Information

Student Services

I,_____, consent to the release of medical information from the following medical providers to a Killeen Independent School District representative regarding my child:

Provider Name:	_____	Provider Name:	_____
Address:	_____	Address:	_____
	_____		_____
Telephone Number:	_____	Telephone Number:	_____

Please initial below in the space provided to confirm your understanding and agreement with the following statements:

_____ (initials) I give my consent for the parties named above to exchange written and/or verbal information regarding my child with the Killeen Independent School District.

_____ (initials) I understand that my consent is voluntary and may be revoked at any time by providing written notice to all of the parties listed above, including KISD. However, my revocation is not retroactive (i.e., it does not negate an action that has occurred after the consent was given and before the consent was revoked).

_____ _____

Parent Signature Date