GRANBURY INDEPENDENT SCHOOL DISTRICT

PREGNANCY RELATED SERVICES – REQUEST FOR MEDICAL INFORMATION

NOTICE FOR RELEASE/CONSENT TO REQUEST CONFIDENTIAL INFORMATION

STUDENT NAME: ________________________________ DOB: _______________

We are asking that you authorize the person or agency named below to release/to request specific records containing confidential information regarding the above-named student.

Granbury Independent School District
NAME OF AGENCY MAKING REQUEST

ADDRESS: ______________________________
Granbury, Texas 76048

FAX NUMBER: 817 - ______________________

____
*PERSON/AGENCY TO WHOM REQUEST IS MADE

ADDRESS: ______________________________
____

FAX NUMBER: ______________________________

*RECORDS TO BE RELEASED/RECORDS REQUESTED	*PURPOSE OF DISCLOSURE
☐ Medical Information as related to Pregnancy	☐ Determination of educational needs ☐ Other

Please check (√) the appropriate box below:

☐ YES ☐ NO **I have been fully informed and understand the school's request for my consent for the release of medical information.**

Date given/mailed: ____________________________ To:______________________________________
NAME

____
STUDENT SIGNATURE

____
DATE

____
PARENT/GUARDIAN SIGNATURE (IF STUDENT IS UNDER 18 YEARS OF AGE)

____
DATE

Please return this form to: ________________________________ at ____________________ as soon as possible.
SCHOOL STAFF PERSON / SCHOOL