ALVIN INDEPENDENT SCHOOL DISTRICT
Department of Federal and Special Programs
Request of Medical- Professional Records

Request for Release of Medical- Professional Records

I do hereby give my consent for the release and exchange of information contained in the medical or professional record of my child.

Child's Name_____ Date of Birth_____

Information Requested: _____

_____

_____

Name of physician, hospital, clinic or professional to be contacted for information:

_____

_____

Address: _____

_____

Telephone: _____

Send information to: _____

Telephone:

Fax Number:

Address:

Signature of Parent/Guardian: _____ Date: _____

Name of Parent/Guardian (please print): _____

Relationship to Child: _____