Red Lick Independent School District
3511 N. FM 2148
Texarkana, TX 75503
903-838-8230 ext.203
FAX 903-831-6134

MEDICAL INFORMATION RELEASE AUTHORIZATION

Student's name_____ Date of Birth_____
School id #_____

I, (parent/guardian)_____ to
(student)_____ hereby authorize
(doctor/agency)_____ to release to, and
receive from Red Lick Independent School District the following:

____Most recent vision exam results and education implications
____Most recent hearing exam results and education implications
____Current Medications
____Current diagnosis
____Health care provider orders (new, revisions, etc.)
____Permission to speak directly with doctor/health care provider/agency representative
____Other (please describe)_____

This consent may be ended at any time by the individual, but ending the consent will not cancel any action that has already been taken as allowed by the form.
It is understood that the duration of this consent will not be longer than would be necessary and reasonable for the purpose for which it is given.

Signature of Parent/Legal Guardian:_____date_____
Signature of Witness:_____date_____