TEMPLE ISD
ATHLETIC DEPARTMENT

Phone: (254)215-7093 Fax: (254)215-6929

Temple Independent School District
Athletic Training Records Release Request

_____

Student's Name Birth date Grade

_____

Sending School (If Applicable) Receiving School (If Applicable)

I hereby authorize the Temple Independent School District to obtain ____ or release ____ pertinent information concerning the above named student. These records will be ethically used in planning the instructional/ athletic program for this child. I have the right to inspect all records of my child.

Agency Releasing Information

Name: _____

Address: _____

_____

Fax: _____

Agency Obtaining Information

Name: _____

Address: _____

_____

Fax: _____

Email: _____

Records Requested: _____ Athletic Physical _____ UIL Paperwork

This authorization for the release of athletic training records, including the release of health information, is valid for one calendar year. It will expire on _____ (insert date). I understand that I may revoke this authorization at any time by submitting written notice of the withdrawal of my consent. I recognize that these records, once received by the school district, may not be protected by the HIPPA Privacy Rule, but will become educational records protected by the Family Educational Rights and Privacy Act.

I, _____ (Relationship: _____) hereby give my permission to have the above records released to the agency designated.

Parent/ Guardian Signature: _____ Date: _____

Requests will be completed within one week of the date that the requested was received.