Little Cypress-Mauriceville CISD
Consent for Disclosure of Confidential Student Information

Student Information (Please Print)

Student Name: ______________________ DOB: ____________ Campus: ______________________

Student Address: ______________________________________ Phone: ______________

This consent is for the disclosure of confidential information for (student named above) between LCMCISD and the third party listed below:

Third Party Contact Information:	LCM CISD Contact Information:
Name(s): ______________	Name: Angela Locke RN
Agency: ______________	Campus/Department: LCJH
Address: ______________	Position: RN
______________	☒ Fax: (409) 670-4626
______________	☐ other Fax: (409) ______________
______________	☒ Phone: (409) 670-4623
Fax: ______________	☐ other Phone: (409) ______________
Phone: ______________	☐ Email: Alocke@lcmcisd.org
Email: ______________	☐ other email: ______________ @lcmcisd.org

Records Requested/to be Released	Purpose of Disclosure
☐ Standardized Test Scores (including STAAR)	☐ Enrolling in LCM School District
☐ Full and Individual Evaluation (including Psychological)	☐ For grade placement
☐ Eligibility Reports	☐ For educational planning
☐ Current ARD reports and IEPs	☐ For scheduling special services
☐ Medical Records (see specific record(s) below)	☐ Maintain communication among people serving student
☐ Other: ______________	☐ Documentation Purposes
______________	☐ Develop Care Plan

☐ Action Plan	☐ Medications Past/Present	☐ Psychiatric/Mental Health Records
☐ Discharge summary	☐ Neuropsychological Testing	☐ Progress Notes
☐ Consultation Reports	☐ Operative Reports	☐ Radiology Reports
☐ Cardiology Reports	☐ Patient Allergies	☐ Other:
☐ History/Physical Exam	☐ Pathology Reports	

Terms of Authorization: Please respond each statement below with a *yes* or *no* and sign at the bottom.

☐ Yes ☐ No I have been fully informed in my native language (other mode of communication) and understand the school's request for my consent as described above.

☐ Yes ☐ No I understand that my consent is voluntary and may be revoked in writing at any time. However, that revocation is not retroactive (i.e does not negate an action that occurred prior to the revocation).

☐ Yes ☐ No I give my consent for the disclosure of confidential information.

Unless otherwise revoked or an earlier expiration date is indicated, this authorization will expire in one (1) calendar year from the date indicated below. Privacy regarding the records described above is protected by the Family Educational Right to Privacy Act (FERPA) and may only be disclosed accordingly. Expiration date of this Authorization:

Signature: ______________________ Printed Name: ______________________

Relationship to Patient: ______________________ Date: ______________

Printed Name of Interpreter, if used: ______________________ Date: ______________

Signature of Interpreter: ______________________