

LISD Health Services
Release of Written Information Authorization Form

To: _____

I Hereby authorize and request you to release written information to _____

The complete medical records in your possession concerning the evaluation and/or
treatment of _____ during the period from
_____ to _____.

Name of Parent/Guardian _____

Child's Date of Birth _____

Address _____

Telephone Number _____

Parent/Guardian Signature _____ Date _____

Witness _____ Date _____