Amarillo Independent School District
Amarillo, Texas
REQUEST FOR RELEASE OF CONFIDENTIAL INFORMATION

Student Name: School: DOB:

Purpose of Request
In order to provide/ receive information regarding your child, AISD needs your written permission. If you give permission, copies of the information will be given to/received by the party (parties) named here:

This is to authorize:	To Provide/Receive Information To/From:
Name:	Name:
Agency: *Amarillo ISD*	Agency:
Address:	Address:
City/State/ZIP:	City/State/ZIP:
Phone Number/FAX Number	Phone Number/FAX Number

Information Type
Educational:
Medical:
Psychological/Psychiatric:
Speech/Hearing:
Other:

This information is requested for the following purpose:

Please respond to each statement with YES or NO and sign at the bottom.

☐ YES ☐ NO I have been fully informed of the record(s) to be disclosed, the purpose of the disclosure, who will disclose the record(s), and who will receive the record(s).
☐ YES ☐ NO I give my consent for the disclosure of confidential information
☐ YES ☐ NO I understand that my consent for the disclosure of confidential information is voluntary and may be revoked at any time. However, that revocation is not retroactive (i.e., it does not negate an action that has occurred after the consent was given and before the consent was revoked.)
☐ YES ☐ NO I understand that my consent, unless revoked, is valid only for the period of **one calendar year** from date of my signature.
☐ YES ☐ NO The information provided to me has been provided in my native language or other mode of communication. If other than English, specify: ___________________________________.

____ _______________________________
Signature of Parent, Guardian, Surrogate or Adult Student Date

____ _______________________________
Printed Name of Above Relationship to Student