Date sent:
_____

Bastrop Independent School District
906 Farm Street
Bastrop, Texas 78602
512.772.7267

NOTICE FOR RELEASE/CONSENT TO REQUEST CONFIDENTIAL INFORMATION

Name:_____ DOB: _____

School: _____ Grade:_____ Student ID: _____

Parent/Guardian:_____ Phone:_____

Home Address:_____

Name of child's Dr. _____
Address of child's Dr. _____
Phone and fax numbers of Dr. _____

Check records to be released/requested	Purpose of disclosure
☐ Treatment Plan ☐ Psychological Evaluations ☐ Medical Records ☐ Notes to School	To assist BISD in educational planning and Homebound Services.

Please circle the appropriate responses below.	
Yes No	I have been fully informed and understand the school's request for my consent, as described above. This information will be released/requested upon receipt of my written consent.
Yes No	I understand that my consent is voluntary and may be revoked anytime.
Yes No	I understand that I will be notified in writing of each release of educationally related information.

_____ _____
Signature of parent/guardian date

_____ _____
Signature of interpreter if used date

Please return this form to: **Suzanne Gambino/Homebound teacher** fax: **512.572.8345**