AUTHORIZATION FOR RELEASE OF INFORMATION

STUDENT: _____ DATE OF BIRTH: _____

CURRENT GRADE: _____ STUDENT ID#:_____ SEX: ___M ___F

PARENT'S NAME: _____ PHONE: _____

ADDRESS: _____ CITY: _____ ZIP: _____

_____ PERMISSION IS GRANTED FOR

_____ PERMISSION IS NOT GRANTED FOR:

_____

AGENCY, SCHOOL, CLINIC, OR PROFESSIONAL

_____

ADDRESS

_____ _____ _____

CITY STATE ZIP

TO RELEASE/EXCHANGE INFORMATION REGARDING THE ABOVE NAMED STUDENT WITH:

_____

AGENCY, SCHOOL, CLINIC, OR PROFESSIONAL

_____

ADDRESS

_____ _____ _____

CITY STATE ZIP

PURPOSE OF DISCLOSURE: _____

NAME AND ADDRESS OF PERSON INITIATING THIS REQUEST: _____

_____

THE SPECIFIC INFORMATION TO BE RELEASED OR EXCHANGED:_____

_____

I have been informed that I have access to and may review any or all of my child's school records and if so desire, to challenge the content of the records provided by the Family Rights and Privacy Act (FERPA) of 1974.

_____ _____

Signature of Parent/Legal Guardian Date