AUTHORIZATION FOR RELEASE OF INFORMATION

STUDENT: _____ DATE OF BIRTH: _____

CURRENT GRADE: _____ STUDENT ID#: _____ SEX: ____ M ____ F

PARENT'S NAME: _____ TELEPHONE: _____

ADDRESS: _____ CITY: _____ ZIP: _____

____ PERMISSION IS GRANTED FOR:

____ PERMISSION IS NOT GRANTED FOR:

_____
School, Agency, Clinic, or Professional

_____
Address

_____ _____ _____
City State Zip

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

_____
School, Agency, 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 Educational Rights and Privacy Act (FERPA) of 1974.

SIGNED: _____ DATE: _____
Parent/Legal Guardian