



AUTHORIZATION TO RELEASE RECORDS FOR STUDENT

Last School attended: _____

Street Address : _____

City: _____ State: _____ Zip: _____

RE: Student Name (S):

Name: _____ Birth Date: _____ Grade: _____

Name: _____ Birth Date: _____ Grade: _____

I hereby give permission for the school district to forward all achievement, scholastic, aptitude, similar standardized test scores, health, medical, and psychological information to the school of attendance.

I acknowledge notification of this transfer of records as required by the Family Educational Rights and Privacy Act of 1974. I understand that I have the right to review these records, and may request a hearing to challenge the content of the records.

I understand that the information transferred will be treated in a confidential manner and will not be transmitted to a third party without my consent.

Parent/Guardian Signature: _____

Date: _____