

Authorization to Obtain Information

Student Name:	Birthday:	Date:
District:		
I hereby authorize the release of information from the following person/agency:		
Check All Appropriate:		
<input type="radio"/> Transcripts	<input type="radio"/> Health Records	
<input type="radio"/> Psychological Records	<input type="radio"/> Counseling Records	
<input type="radio"/> Special Education Records	<input type="radio"/> Police Records	
<input type="radio"/> School Records	<input type="radio"/> Other:	
I understand that the information obtained will be treated in a confidential manner and will not be transmitted to a third party. I also understand that it is my right to request a copy of all information and that I may contest any information I feel is incorrect.		
Parent Name (Printed):	Parent Signature:	
Parent Address:		