



**AUTHORIZATION TO RELEASE PUPIL RECORDS AND INFORMATION**

STUDENT NAME: \_\_\_\_\_ GRADE: \_\_\_\_\_

ADDRESS: \_\_\_\_\_ CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_

DATE OF BIRTH: \_\_\_\_\_ SOCIAL SECURITY#: \_\_\_\_\_

NAME AND ADDRESS FROM WHOM RECORDS ARE BEING REQUESTED:

SCHOOL: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

CITY: \_\_\_\_\_ STATE: \_\_\_\_\_

PHONE: \_\_\_\_\_ FAX#: \_\_\_\_\_

**Please fax or send copies of the following information:**

Educational Cumulative records

Medical/Immunizations

Discipline Files

Psychological

Social

Outside Agency

Special Education Records (IEP program providing date designation of handicap and Diagnostic Summary providing testing results and designation of handicap.)

I authorize the release of the records indicated above:

\_\_\_\_\_  
Signature of Parent/Guardian

\_\_\_\_\_  
Date