APPENDIX E

Independent School District 279
Osseo Area Schools

AUTHORIZATION FOR RELEASE OF SCHOOL RECORDS

Name of Person/School/District ____

Address____
(city/state) (zip code)

You have my permission to release the following information from your files and to discuss this information with authorized personnel regarding:

Student ________________________________ Birth date______________________

School Last Attended ____

Information to be released:

Identifying Information	YES ___	NO ___	Psychological Reports	YES ___	NO ___
Attendance	YES ___	NO ___	Graduation Data	YES ___	NO ___
Health Record	YES ___	NO ___	Report Cards/Grades	YES ___	NO ___
Standardized Test Data	YES ___	NO ___	Extracurricular Activities/Honors	YES ___	NO ___
Conference Reports	YES ___	NO ___	Teacher/Counselor/Observations/ Ratings	YES ___	NO ___
Special Education Reports	YES ___	NO ___	Disciplinary Records	YES ___	NO ___

Other:

Purpose of request: ____

____

Send the above-indicated information to:

____
(Name of person, educational institution or agency)

____
(Street Address)

____
(City, State and Zip Code)

____
(Signature of adult student authorizing release of own records/reports)

____
Signature of parent/guardian of minor student authorizing of student's records and reports)

____
(Date of Authorization)

(Valid for one year from date of authorization)

____
(Date of Authorization)

REQUEST COMPLETED BY ______________________ Date ____________