AUTHORIZATION TO RELEASE RECORDS

Request for transfer of educational, psychological and medical records between schools

PREVIOUS SCHOOL ____

DISTRICT ____

STREET ____

CITY_________________________STATE__________ZIP__________________

PHONE__________________________ FAX____________________

Please forward complete cumulative records on the following student(s) who have enrolled in our school:

Student name(s):	Birthdate:	Grade:

Please include:
- ☐ Academic Progress Records
- ☐ Behavioral Records
- ☐ Health and Immunization Records
- ☐ Other: _________________________

I hereby authorize notification of this transfer of records as required by the Family Educational Rights and Privacy Act of 1974 and understand that I have a right to receive a copy at my own expense, if requested and have an opportunity for 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.

Signed____ Date______________________
Signature of parent/guardian

New address____

City__________________ State_____ Zip________

Please send records to:

SCHOOL NAME ____
STREET ____
CITY_________________________STATE__________ ZIP________________
PHONE________________________ FAX____________________