



**Saraland City Schools
Special Services Department**

Student Name: _____

Date of Birth: _____

School: _____

Authorization for Release of Information

I, the parent/legal guardian of the above referenced student, hereby authorize the designated agent below to communicate with, receive records from, and release any and all pertinent information to the Special Services Department of Saraland City Schools. Copies of psychological evaluations, pertinent medical records, and all school records, including any special education records, will be used by professional personnel. These records are confidential and maintained in a secure location.

Designated Agent Address

Send records to:

Saraland City Schools
4010 Lil' Spartan Drive
Saraland, AL 36571
Attention: Amy Pippins
Phone: 251-375-5420
Efax: 1-251-216-4098
apippins@saralandboe.org

Parent/Guardian Printed Name _____

Parent/Guardian Signature _____

Date _____