



Public Schools of the Tarrytowns

AUTHORIZATION OF RELEASE

I, _____ of _____
Name of parent/guardian Student's name and date of birth

consent to, _____
School, agency, or clinic releasing information

_____, _____
Phone number Fax number

To release any records and information requested or required by the staff of the Public Schools of the Tarrytowns.

Requested Records:

___ **Medical**

___ **Educational**

___ **Psychological/Psychiatric**

___ **Special Education**

___ **Grades/Qualifications**

___ **Other relevant school/agency records**

Parent/Guardian Signature

Date