USD 305 Authorization for RELEASE OF INFORMATION

Salina Virtual Innovation Academy
811 E Iron
Salina, KS 67401
Phone: 785-309-4369
FAX: 785-309-4311

_____ Date of Birth: _____
PRINT STUDENT NAME (while attending SVIA)

Year of Graduation / or last date of attendance: _____

I hereby authorize Salina Virtual Innovation Academy to release my records to:

NAME OF SCHOOL / PROGRAM / EMPLOYER (include address, phone/FAX, and/or email)	DATE	OFFICIAL COPY? Yes	No
_____	___/___/___	☐	☐
_____	___/___/___	☐	☐
_____	___/___/___	☐	☐
_____	___/___/___	☐	☐
_____	___/___/___	☐	☐

Student Contact Phone #:_____ Student email: _____

Student address:_____City:_____ST: ____ Zip: _____

Type of information to be released: (check all that apply)

☐ Transcript

☐ Grades / Progress Report

☐ ACT / SAT / Assessment Scores

PLEASE NOTE: Emailed and personal copies are not certified (official) transcripts.
ONLY transcripts mailed directly to a college or employment firm will be certified.

I authorize _____ to pick up my records.

Student Signature* _____ Date _____

Parent / Guardian Signature _____ Date _____

** If the student is UNDER 18 years of age, this form must also be signed by parent / guardian.*
If the student is OVER 18 years of age, this form must be signed by the student.