



AUTHORIZATION FOR RELEASE OF INFORMATION

ARCHDIOCESE OF WASHINGTON – Catholic Schools

Student's Name: _____ Sex: Male Female Birth Date: _____
Print Student's Legal Name *mm/dd/yyyy*

Parent/Guardian Name: _____

Home Address: _____

Home Phone: () - Work Phone: () - Ext.

Release of Student Information

I, _____, hereby AUTHORIZE _____
Parent/Guardian's Full Name *School Name*

to disclose/receive _____'s identifiable information as described below:
Print Student's Legal Name

The following information may be shared with the entity below *And/Or* received from the entity below

The following records **ONLY**: (please check all that apply)

- Academic Records
- Assessments (specify): _____
- Behavioral Records/Plans
- CAP/ICEP
- Evaluations (specify): _____
- Medical Information
- Recommendations
- Other (specify): _____

Reason for the release of information...

- To aid in making present and future educational decisions (includes transferring schools):
- Other (please specify): _____

I AUTHORIZE the release of the aforementioned information (existing in the school's records at the date listed immediately below), regarding my child to:

School/Agency/Institution: _____
Print Name of School/Agency/Institution to Where the Student's Information Will Be Used or Disclosed

Contact Person(s): _____ Phone No. () - Ext.
Print Name of Contact Person at the School/Agency/Institution

School/Agency Address: _____

Duration for Disclosure: From: _____ Until: _____
Specify Date *Specify Date*

I understand that I may revoke this authorization at any time by submitting revocation in writing.

Name of Parent/Guardian: _____
Print Parent/Guardian Full Name

Signature of Parent/Guardian: _____ Date: _____
Sign Your Name *Today's Date*