FORM 19

AUTHORIZATION FOR RELEASE OF INFORMATION

ARCHDIOCESE OF WASHINGTON – Catholic Schools

Student's Name: _____ Sex: ☐ ☐ Birth Date: _____
Print Student's Legal Name Male Female *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*