

Authorization to Release Records

Request for transfer of educational, psychological and medical records between schools.

Previous school:

District:

Street:

City:

State:

Zip:

Phone:

Fax:

Please forward complete cumulative records to the following student(s) who have enrolled in our school:

Student name(s):	Birthdate:	Grade:

Please include:

- ☐ Academic Progress Records
☐ Behavioral Records
☐ Health and Immunization Records
☐ Other: _____

I hereby authorize notification of this transfer of records as required by the Family Educational Rights and Privacy Act of 1974 and understand that I have a right to receive a copy at my own expense, if requested and have an opportunity for a hearing to challenge the content of the records. I understand that the information transferred will be treated in a confidential manner and will not be transmitted to a third party without my consent.

Signature of parent/guardian:

Date:

New address:

City:

State:

Zip:

Please send records to:

School name:

Date:

Street:

City:

State:

Zip:

Phone:

Fax:

Our students will be contributing members of society and lifelong learners, pursuing their passions and interests in an ever-changing world.