Authorization for Release of Records

Date: _____ Student Name:_____

I, the undersigned, authorize St. Charles School to:

____Release the following records/information to:

____Receive the following records/information from:

____Exchange the following records/information with:

Name and address of agency, person or office _____

_____

_____

_____

Records/information to be released: _____

_____

_____

_____

I have read and understand the above and acknowledge that it was properly completed prior to my signature.

_____ _____

Parent/Guardian School Official

_____ _____

Date Date