**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* | |  | | *Print School’s Name* | | | to use or disclose | |  | | ’s identifiable information as described below: | | | |  | | *Print Student’s Legal Name* | |  | | | |

|  |  |  |
| --- | --- | --- |
| The following information may be shared…  **ALL** personally identifiable data on file  **OR** The following records **ONLY:** *(please check ✓ all that apply)* | | |
| Assessments/Evaluations  Behavioral Records/Plans  Academic Records | | Medical Information  Counseling Records  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: | | | | | Our Lady Star of the Sea School | | | | | | | | | |
| *Print Name of School/Agency/Institution to Where the Student’s Information Will Be Used or Disclosed* | | | | | | | | | |
| Contact Person: | Amber Tamburri | | | | | | Phone No. | | **( 410 ) 326 - 3171 Ext.** | | | |
|  | *Print Name of Contact Person at the School/Agency/Institution* | | | | | |  | | | | | |
| School/Agency Address: | | | | | **PO Box 560, Solomons, MD 20688** | | | | | | | |
|  | | | | |  | | | | | | | |
| 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 to . | | | | | | | | | | | | | | |
| Name of Parent/Guardian: | | |  | | | | | | | | | | | |
|  | | | *Print Parent/Guardian Full Name* | | | | | | | | | | | |
| Signature of Parent/Guardian: | | | | |  | | | | | | | Date: | 1/4/2022 | |
|  | | | | | *Sign Your Name* | | | | | | |  | *Today’s Date* | |