



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 *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)*
- | | |
|--|--|
| <input type="checkbox"/> Assessments/Evaluations | <input type="checkbox"/> Medical Information |
| <input type="checkbox"/> Behavioral Records/Plans | <input type="checkbox"/> Counseling Records |
| <input type="checkbox"/> Academic Records | <input type="checkbox"/> Recommendations |
| <input type="checkbox"/> Other <i>(specify):</i> _____ | |

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: _____ 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 to (school): _____

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

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