AUTHORIZATION TO EXCHANGE INFORMATION

Student's Legal Name: _____ Date: _____

(Last/First/Middle) (mm/dd/yyyy)

Date of Birth: _____

(mm/dd/yyyy)

School District: _____

I hereby authorize the exchange of information with the agency/person(s) listed below:

_____

_____

_____

_____

_____

Check all appropriate:

- ☐ Transcripts
- ☐ Health records
- ☐ Psychological and counseling
- ☐ Special Education records
- ☐ Police Records
- ☐ Other (specify) _____

I understand that the information obtained will be treated in a confidential manner and will not be transmitted to a third party. I also understand that it is my right to request a copy of all information and contest any information I feel is incorrect.

_____ _____

Parent/Guardian Signature Address

_____ _____

Date