AUTHORIZATION FOR RELEASE AND/OR DISCLOSURE OF SCHOOL RECORDS

STUDENT'S NAME: _____

DATE OF BIRTH: _____

PRESENT ADDRESS: _____

EMAIL ADDRESS: _____

PHONE NUMBER: _____

FAX NUMBER: _____

Please send transcript and/or records to:

College/School/District: _____

Street Address: _____

City: _____

State: _____

Zip Code: _____

Please specific records to be released:

- ☐ IEP
- ☐ Triennial
- ☐ Audiogram
- ☐ Transcript
- ☐ Other: _____

Print Name: _____

Signature: _____

Date: _____

A COPY OF YOUR DRIVER'S LICENSE AND/OR STATE ID IS REQUIRED TO FULFILL THIS REQUEST.