PERMISSION TO RELEASE INFORMATION

Student: _____ Birthdate: _____

I HEREBY AUTHORIZE _____ TO SEND THE FOLLOWING INFORMATION TO:

All Saints Catholic School
139 West Rocks Road
Norwalk, CT 06851
Phone 203-847-3881 Fax 203-847-8055

_____ TRANSCRIPT AND CUMULATIVE RECORD DATA

_____ STANDARDIZED TEST SCORES

_____ HEALTH RECORDS

_____ SPECIAL EDUCATION/STUDENT SERVICES RECORDS (I.E.P., P.P.T. MINUTES, PSYCHOLOGICAL, SOCIAL WORK, SPEECH/HEARING)

_____ OTHER AS SPECIFIED: _____

_____ _____
(Date) (Signature)

_____
(Relationship to Student)

THE INFORMATION REQUESTED WAS RELEASED ON: _____
(Date)

BY: _____

PLEASE DROP OFF THIS FORM AT YOUR CHILD'S CURRENT SCHOOL