Student Education Records/Information Release Form

Student Name: _____ DOB: _____

_____ Grades/Transcripts
_____ Medical/Health Records
_____ Standardized Test Scores
_____ Confidential Records
_____ Special Education Records

Please release the above information to:

Assumption Catholic School
605 Stratfield Road
Fairfield, CT 06825
Fax: 203-382-0399
P: 203-334-6271

Please obtain the above information from:

_____
_____
_____
_____
_____

Authorization

_____ _____
Signature *Relationship to Student*

_____ _____
Date *Reason of Release of Records*

This is to acknowledge that the above identified records/information have been released by:

_____ _____
Signature of School Representative *Date of Record Release*
