IMMACULATE CONCEPTION SCHOOL
AUTHORIZATION TO RELEASE OR TRANSFER STUDENT RECORDS

I hereby authorize the following school:

_____
School

_____
Address

_____
Phone Number

To release the school records of:

Student's Name: _____
Date of Birth: _____

Specific records to be released:

__X__ All personally identifiable data on file including: IEP/Service Plans, academic records, attendance records, health records, birth certificate, legal papers, and all psychological testing information.

_____ The following records only: _____

_____

Reason for request:

__X__ Student transferring to Immaculate Conception School

_____ Other: _____

_____

Records are to be released to:
Immaculate Conception School
100 Sherman St.
Dennison, OH 44621
Phone: 740-922-3539
Fax: 740-922-2486

Parent/Guardian Name (please print): _____

Parent/Guardian Signature: _____

Date: _____