FORM 19

AUTHORIZATION FOR RELEASE OF INFORMATION

ARCHDIOCESE OF WASHINGTON – Catholic Schools

Student's Name: _____ Sex: ☐ ☐ Birth Date: _____
Print Student's Legal Name Male Female *mm/dd/yyyy*

Parent/Guardian Name: _____

Home Address: _____

_____

Home Phone: **( ) -** _____ Work Phone: **( ) - Ext.** _____

Release of Student Information

I, _____ **, hereby AUTHORIZE** **St.Raphael School**
Parent/Guardian's Full Name *Print Institution's Name*

to use or dis lose _____ **'s identifiable information as described below.**
Print Student's Legal Name

The following information may be shared…

☐ **ALL** personally identifiable data on file **OR** The following records **ONLY:** *(please check ✓ all that apply)*

☐ Assessments/Evaluations ☐ Medical Information
☐ Behavioral Records/Plans ☐ Counseling Records
☐ Academic Records ☐ Recommendations
☐ Other *(specify):* _____

Reason for the release of information…

☐ To aid in making present and future educational decisions *(includes transferring schools):*
☐ Other (*please specify*): _____

I AUTHORIZE the release of the aforementioned information (exisiting in the institution's records at the date listed immediately below), regarding my child to:

School/Agency Name: _____
Print Name of School/Agency

Contact Person: _____ Phone No. **( ) - Ext.** _____
Print Name of Contact Person at the School/Agency

School/Agency Address: _____

_____

Duration for Disclosure: From _____ Until: _____
Specify Date *Specify Date*

I understand that I may revoke this authorization at any time by submitting revocation in writing to <<Enter School Name Here>>.

Name of Parent/Guardian: _____
Print Parent/Guardian Full Name

Signature of Parent/Guardian: _____ Date: _____
Sign Your Name *Today's Date*