

**REQUEST FOR RELEASE OF EDUCATIONAL INFORMATION**

Pupil's Last Name	First	Initial	Date of Birth
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Please release cumulative, psychological or medical information concerning the student(s) listed above to the following agency or individuals:

Name of School	Date
Street Address	By
City	Title

Approved by: \_\_\_\_\_  
Signature of Parent or Guardian

I understand that this information will be treated confidentially and used to facilitate the education of my child(ren) in accordance with the Federal Law, HR-69, "Family Rights and Privacy Act."