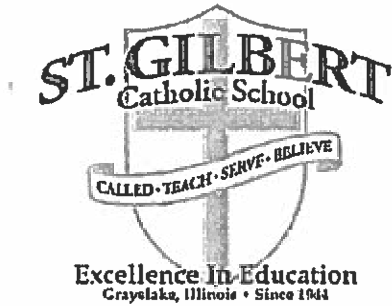

Release of Records Authorization Form

Student's Name: ______________________________________

Students Date of Birth: ______________________________________

Student's Last Grade Completed: ______________________________

I hereby give permission for the release of all school and health records, including any Special Education information regarding the student listed above to St. Gilbert Catholic School.

Name of Previous School: ______________________________________

Street Address: ______________________________________

City, State, Zip Code: ______________________________________

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Date: Signature of Parent Legal Guardian: