FORM 19

AUTHORIZATION FOR RELEASE OF INFORMATION

ARCHDIOCESE OF WASHINGTON – Catholic Schools

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

Parent/Guardian Name: _____

Home Address: _____

_____

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

Release of Student Information

I, _____ **, hereby AUTHORIZE** _____
Parent/Guardian's Full Name ***School Currently Attending***

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

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: **St. JOHN'S SCHOOL**
Print Name of School/Agency

Contact Person: **SUSAN McDONOUGH** Phone No. (301) 373 - 2142 **Ext.**
Print Name of Contact Person at the School/Agency

School/Agency Address: 43900 ST. JOHN'S RD

HOLLYWOOD MD 20636

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

I understand that I may revoke this authorization at any time by submitting revocation in writing to St. John's School.

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

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