



**PARENTAL PERMISSION TO  
RELEASE/REQUEST INFORMATION**

To improve a student's educational program, it is often necessary to exchange information with other schools, agencies and professionals. Before we can exchange information, we need your written authorization. Please complete, sign and return this form to:

Mrs. Marianne Gano, Principal  
St. Michael the Archangel School  
5040 St. Josephs Rd.  
Coopersburg, PA 18036

DATE: \_\_\_\_\_

NAME OF STUDENT: \_\_\_\_\_ BIRTHDATE: \_\_\_\_\_

I hereby authorize St. Michael the Archangel School to request the following information:

\_\_\_\_\_ All student records including but not limited to academic, medical & dental, educational testing, psychological testing or evaluations, behavioral reports and any other student records relating to aforementioned student.

\_\_\_\_\_ Other: \_\_\_\_\_

To: \_\_\_\_\_  
(Name of School/Agency/Professional)

\_\_\_\_\_  
(Address)

\_\_\_\_\_  
(Phone)

\_\_\_\_\_  
(Fax)

\_\_\_\_\_  
Signature of Parent/Guardian

\_\_\_\_\_  
Date