Holy Family Catholic High School

CONSENT TO RELEASE PRIVATE DATA

Student's Full Legal Name: ______________________________

Current Grade: ______ Student DOB: ___ /___/_____ Gender: _____

Parent/Guardian Name(s): ______________________________

Parent/Guardian Address: ______________________________

City: ________________ ________________ State:_______ Zip:_________

Authorization:

I authorize HOLY FAMILY CATHOLIC HIGH SCHOOL to obtain information from:

Name of School: ______________________________

Address: ______________________________

City: ________________ State:_______ Zip:_________

The information to be released:

- Official School Records (e.g., name, address, attendance record, grades, test results, behavior)
- Standardized Testing Results
- Health Records
- Psychological Records
- Social Work Reports
- Current School Counselor Observations
- Chemical Abuse/Dependency Report
- Medical Reports (including related services)
- Special Education Results (including related services)
- Other: ______________________________

I understand that student records may be examined by parent/guardian(s) or the student if age 18 or older. I understand that this authorization takes effect the day I sign it. I understand I may change or revoke this authorization at any time.

This authorization expires on ____________________ or no more than one year from the date of my signature.
Expiration Date

________________ ________________ ________

Print (Parent/Guardian) Signature (Parent/Guardian) Date

Please send the requested materials to:

Holy Family Catholic High School
Attn: Records Office
8101 Kochia Lane
Victoria, MN 55386
School: (952) 443-4659 I Fax: (952) 443-1822 | Email: schooloffice@hfchs.org
www.hfchs.org