ST. MARK SCHOOL

A Nationally Recognized Blue Ribbon School of Excellence

Authorization to Release School Records to Other Schools and Agencies

Student Name: _____ Grade Entering: _____
(LAST) (FIRST) (M.I.)

Date of Birth: ____/____/_____

I hereby authorize _____
(SCHOOL)

_____
(ADDRESS)

_____
(TOWN) (STATE) (ZIP)

to release the following information regarding my child:

- ☐ Administrative Records (contained in cumulative folder)
- ☐ Supplementary Records (special information: such as results of psychological testing, planning and placement team reports and other diagnostic information
- ☐ Medical Records (including psychiatric, neurological and/or other diagnostic information)

The information is to be released to the following:

ST. MARK SCHOOL
500 WIGWAM LANE
STRATFORD, CT 06614

Parent/Guardian Signature_____Date_____

Address_____

Town, State, Zip_____