

SAINT ALBERT CATHOLIC SCHOOLS

REQUEST TO RELEASE RECORDS

This will authorize _____
(Name of Previous School or Agency)

Street City State Zip

to release all information including, but not limited to: psychological, emotional, social, medical, current Individualized Education Program (if child is in special education), and other available educational reports and/or evaluations for me or my child to:

Saint Albert Catholic Schools
400 Gleason Avenue
Council Bluffs, IA 51503
Attention: Registrar

Primary School (Prek-3rd)	Phone: (712) 323-3703	Fax: (712) 323-6132
Intermediate School (4-6th)	Phone: (712) 322-7004	Fax: (712) 322-0399
Jr/Sr High (7-12th)	Phone: (712) 328-2316	Fax: (712) 328-8316

for: _____
Name of Student Grade Entering Date of Birth

* _____
Parent/Guardian Signature Date

Authorized School Official Date

*According to the Final Regulations-Family Educational Rights and Privacy Act (Buckley Amendment) dated June 17, 1976, it is no longer necessary to obtain written consent to release records between schools. It states that school officials in school systems in which the student may intend to enroll may receive a student's records without a written consent for such release.