

**APPENDIX E**

Independent School District 279  
Osseo Area Schools

**AUTHORIZATION FOR RELEASE OF SCHOOL RECORDS**

Name of Person/School/District \_\_\_\_\_

Address \_\_\_\_\_  
(city/state) (zip code)

You have my permission to release the following information from your files and to discuss this information with authorized personnel regarding:

Student \_\_\_\_\_ Birth date \_\_\_\_\_

School Last Attended \_\_\_\_\_

Information to be released:

Identifying Information	YES ___ NO ___	Psychological Reports	YES ___ NO ___
Attendance	YES ___ NO ___	Graduation Data	YES ___ NO ___
Health Record	YES ___ NO ___	Report Cards/Grades	YES ___ NO ___
Standardized Test Data	YES ___ NO ___	Extracurricular Activities/Honors	YES ___ NO ___
Conference Reports	YES ___ NO ___	Teacher/Counselor/Observations/ Ratings	YES ___ NO ___
Special Education Reports	YES ___ NO ___	Disciplinary Records	YES ___ NO ___

Other:

Purpose of request: \_\_\_\_\_

Send the above-indicated information to:

\_\_\_\_\_  
(Name of person, educational institution or agency)

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

\_\_\_\_\_  
(City, State and Zip Code)

\_\_\_\_\_  
(Signature of adult student authorizing release of own records/reports)

\_\_\_\_\_  
Signature of parent/guardian of minor student authorizing of student's records and reports)

\_\_\_\_\_  
(Date of Authorization)

\_\_\_\_\_  
(Date of Authorization)

(Valid for one year from date of authorization)

REQUEST COMPLETED BY \_\_\_\_\_ Date \_\_\_\_\_