MURRAY CITY SCHOOLS
Department of At Risk Programs
147 East 5065 South
Murray, UT 84107
Telephone (801) 264-7400  Fax (801) 264-7427

AUTHORIZATION FOR RELEASE OF RECORDS

I. Student’s Name ___________________________ Birthdate __________________

I authorize the release of the following records:

☐ Social  ☐ Educational (including testing data)
☐ Medical  ☐ Other __________________________

I request that the information be kept confidential, be used for professional reasons only, and not be released to another individual or organization unless authorized by me.

Signed ___________________________ Date ___________________________

☐ Parent  ☐ Guardian  ☐ Self

II. Information to be released from:  III. Information to be released to:

School, Department, Agency ____________________________

Address ___________________________________________

City, State, Zip _______________________________________

Contact Person _______________________________________

Telephone _______ Fax _______

School, Department, Agency ____________________________

Address ___________________________________________

City, State, Zip _______________________________________

Contact Person _______________________________________

Telephone _______ Fax _______

INSTRUCTIONS:

1. Section I should be completed by the parent, guardian, or person requesting the information.
2. Section II should specify name and address of school or organization holding records.
3. Section III should specify name and address of person and/or school to which records are to be sent.

Use This Form When:
Releasing information to other organizations or obtaining information from other organizations.