Inspiring Excellence

LAKE STEVENS
School District

AUTHORIZATION TO RELEASE RECORDS

Request for transfer of educational, psychological and medical records between schools

PREVIOUS SCHOOL _____

DISTRICT _____

STREET _____

CITY_____STATE_____ZIP_____

PHONE_____ FAX_____

Please forward complete cumulative records on the following student(s) who have enrolled in our school:

Student name(s):	**Birthdate:**	**Grade:**

Please include:

- ☐ Academic Progress Records
- ☐ Behavioral Records
- ☐ Health and Immunization Records
- ☐ Other: _____

I hereby authorize notification of this transfer of records as required by the Family Educational Rights and Privacy Act of 1974 and understand that I have a right to receive a copy at my own expense, if requested and have an opportunity for a hearing to challenge the content of the records. I understand that the information transferred will be treated in a confidential manner and will not be transmitted to a third party without my consent.

Signed_____ Date_____
Signature of parent/guardian

New address_____

City_____ State_____ Zip_____

Please send records to:

SCHOOL NAME _____
STREET _____
CITY_____ STATE_____ ZIP_____
PHONE_____ FAX_____