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AUTHORIZATION TO RELEASE STUDENT FILE INFORMATION

I hereby authorize _____ to send all necessary and
Name of school

Requested information of my child, _____'s academic and health
Name of student

record to Nathan Hale-Ray Middle School, P.O Box 363, Moodus, CT 06469.

- Please check the documents you wish to be released:

___Psychological Reports

___Medical Reports

___Educational Reports

___Psychiatric Evaluations

___Speech/Hearing/Language Reports

___Evaluations from outside agencies, doctors, schools

___All of the above

___Other

- Reason for requesting release of records:

___Transfer to another school

___Other

Signed: _____
Parent/guardian signature Date

Address of former school: _____

Request mailed/faxed: _____