REQUEST FOR TRANSFER OF RECORDS FOR STUDENTS

I HEREBY GIVE CONSENT TO THE RELEASE OF INFORMATION:

FROM__ TO__: School _________________

Address________________

City, State, Zip________________

Phone__________________ Fax:____________

FROM__ TO__: Saint Alphonsus Liguori School

411 N. Wheeling Road

Prospect Heights, IL 60070

(847) 255-5538 FAX (847) 255-0353

TO RELEASE THE FOLLOWING INFORMATION REGARDING:

_________________________ _________________

Student's Name Grade

_____ Cumulative school records

_____ Health Records

_____ Confidential files…if applicable

(Psychological, special services)

_____ Other _______________________________

__________________________ ______________

Parent/Guardian Signature Date