Consent for Release of Student Records

Instructions: This form authorizes the Columbia Borough School District to disclose information from the student record. Complete the form, sign where indicated, and return the completed form to the requesting office or individual.

Student Information

Student's Last Name	Student's First Name	Student's DOB	Phone Number

Mailing Address	City/State/Zip	School

Student Record(s) Authorized to be Released (mark all that apply)

□ Cumulative	□ Health	□ Discipline	□ Psychological	□ Special Education

□ Other, please specify: _____

Office/Individual to Whom Records are to be Released

Name	Business/Company Name

Mailing Address/City/State/Zip	Phone Number

Authorization and Certification

I certify that I am the parent and legal guardian of the student, or eligible student if age 18* or older.

I hereby authorize the Columbia Borough School District to release the student record(s) identified above. I understand that the recipient of the student record(s) will use the record(s) for legitimate interests only and that the information contained therein shall not be further transferred or communicated to any other party or agency without my expressed written consent except under authority of the Educational Rights and Privacy Act, 20 U.S.C. §1232g.

_____ _____

Parent/Guardian Name (Please Print) Eligible (18+) Student Name (Please Print)

_____ _____

Parent/Guardian Signature Date Eligible Student Signature Date

**Note: Student signature is required for release of mental health records for a student over age 14.*

Revised: 07/19/2021