Name of Student (please print):

_____

Address: _____

_____

Telephone Number: _____

Under Federal legislation, namely the "Family Educational Rights and Privacy Act of 1974", I understand that my educational records (including medical records) cannot be released without my written permission or a Parental Affidavit of Dependency certified by my parent or guardian.

I, therefore, request that the information listed below be released to the following:

Name: _____

Address: _____

_____

Telephone Number: _____

Information to be released: _____

Purpose: _____

Signed this day of: _____

Signature of Student: _____

*3100 South Parker Rd. * Aurora, Colorado 80014 * (303) 369-5151*
*Fax (303) 745-1433 * www.plattcolorado.edu*