

Authorization for Release of Pupil Records

Please Complete Form

Student _____ Birth Date _____
(Maiden name if applicable)

Address _____ Phone _____

Last School Attended in District _____

Date of graduation/withdrawal _____
from our District

I hereby request and authorize the Flagstaff Unified School District to release pupil records or other pertinent information you may have, or may receive, pertaining to this student. This is in compliance with the "Family Educational Rights and Privacy Act of 1974."

When a student has reached eighteen years of age, the permission or consent required of and the rights accorded to the parents of the student shall thereafter be required of and accorded to the student.

**Signature of Parent or Guardian or
Student's signature if over 18 years of age**

Date

Address to be mailed to:

Special instructions:

