Authorization and Permission to Release
Medical, Educational and/or Psychological Records

Today's Date: ____________________

I hereby authorize ___________________________________ (previous school) to release all **Medical, Educational, and Psychological** information which has been a part of the school records regarding:

Student's Name: ____________________________________

Please send or fax to:

Queen of All Saints Catholic School
1715 East Barker Avenue
Michigan City, IN 46360
Fax: 219.872.1943

_____________________________________ Authorizing signature

_____________________________________ Title or relationship to student