CHIARAVALLE ACADEMY
ENFIELD STREET, ENFIELD, CT 06082

RELEASE AND RECEIVE PERSONALLY IDENTIFIABLE INFORMATION

I give my permission to Chiaravalle Academy to release and receive records of _____

_____ as specified below to and from the following party or class of parties for the
(Student's Name)
purpose(s) stated.

Party or Class of Parties to whom Disclosure May Be Made: _____

_____

_____

_____

Records to be Disclosed:

- ☐ **Academic**
- ☐ **Health**
- ☐ **Grades to Date of Withdrawal**
- ☐ **All Confidential Materials**
- ☐ **All Medical Records**
- ☐ **Tests**
- ☐ **Attendance**
- ☐ **Special Education Records**
- ☐ **All Educational Records**
- ☐ **Other** _____

Purpose(s) for Disclosure: _____

_____

_____

_____

_____ _____

Signature of Parent/Guardian **Date**

Any personally identifiable information obtained by the recipient cannot be disclosed to a third party without the prior written permission of the parent or guardian of the student.

_____ _____

Signature of Authorized School Official **Date**

_____

Title of Authorized School Official