THE MARSHALL SCHOOL

# Authorization to Request / Release Student Records

To: _____ (School Name)

_____ (Address)

_____ (City, State ZIP)

_____ (Phone Number)

_____ (Email)

I request that all records listed below for

_____ _____ _____

*Last* *First* *MI*

_____ _____

*Date of Birth* *Grade*

be sent to:

**The Marshall School**
**5707 Salem Run Blvd.**
**Fredericksburg, VA 22407**
**TEL: (540) 412-0992**
**FAX: (540) 412-5204**
**EMAIL: christina@themarshallschool.org**

Records include:

| | |
|---|---|
| _____ Academic Records<br>- attendance<br>- transcripts | _____ Test Records<br>- standardized test results |
| _____ Health Records<br>- immunization record | _____ Confidential Records<br>- All Special Education Records |
| _____ Other | |

_____ _____

*Parent or Guardian's Signature* *Date*

_____

*Parent or Guardian's Printed Name*