Parental Authorization for Release of Confidential Student Records

Date :_____

I authorize the transfer of all records pertaining to _____
Name of Student

to be sent from _____
Name and address of school transferring from

to be sent to : Saints Peter & Paul School
502 7th Street
Boonville MO 65233
660-882-2589 660-882-2476 fax

I understand I may request, from the above authorized school, a copy of the records to be transferred, if desired.

_____ Signature of parent(s)/guardian(s)

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