

AUTHORIZATION TO RELEASE INFORMATION ABOUT A STUDENT
Catholic Schools Office
Archdiocese of Galveston-Houston

AUTHORIZATION IS HEREBY GRANTED TO:

Name of Agency sending information or records

to release information from the Social/Psychological/Medical/Educational records of:

Name of Student

TO:

Agency receiving information or records

ADDRESS:

Attention to:

Street

City

Authorized Signature of Parent/Guardian

Date