

SACKETS HARBOR CENTRAL SCHOOL DISTRICT

**P.O. Box 290, Broad Street
Sackets Harbor, NY 13685
(315) 646-3575
Fax (315) 646-1038**

AUTHORIZATION TO RELEASE STUDENT EDUCATION RECORDS

I, _____ hereby authorize

(Name of school and address)

to release any and all academic, health, and confidential information from the
records of _____ to
the following.

**SEND TO: SACKETS HARBOR CENTRAL SCHOOL DISTRICT
P.O. Box 290, Broad Street
Sackets Harbor, NY 13685**

Date

Signature of Parent or Legal Guardian

