

Brookhaven Innovation Academy

**REQUEST AND AUTHORIZATION FOR
RELEASE OF STUDENT RECORDS**

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STUDENT INFORMATION

Legal Last Name:		Legal First Name:		Legal Middle Name:	Suffix:
Grade:	Gender: <input type="checkbox"/> M <input type="checkbox"/> F	Birth Date:		Social Security Number/FTE Number:	

SCHOOL RECORDS ARE REQUESTED FROM

Name of School: Brookhaven Innovation Academy		School Address: 186 Hunter Street	
City: Norcross		State: Georgia	Zip Code: 30071
Phone: (including area code) 770-538-1550		Fax Number: (including area code) 678-791-6207	

RECORDS TO BE RELEASED

Mail the following records of the above named student: * only checked items will be released

- Cumulative record including grades and attendance
- Report Cards with current grade averages and academic transcript
- Immunization and health/medical records
- Standardized test scores
- Discipline Records
- Special placement records and reports (including IEP's)
- Other (Specify) _____

RELEASE SCHOOL RECORDS TO

Name of School / Person / Company:	Address:	Phone: (including area code)
City:	State:	Zip Code:

PARENT/LEGAL GUARDIAN SIGNATURE

I, the parent/legal guardian of the above named student, hereby authorize the above named school to release any of the listed school records to the indicated school. I further authorize this receiving person or agency to release to the personnel of the school district any or all information regarding the student which pertains to his/her educational, physical and social adjustment in school. I further understand that I may review the transferred records by making such request of the principal, and may also have all or any part of these records properly interpreted as necessary by appropriate school personnel.

Parent/Legal Guardian Signature: <i>(Required)</i>	Relationship to Student:	Date:
Signature of Witness:	Business Phone of Witness:	Date:
Business Address of Witness:	City/State/Zip:	

* If over 18 years of age, the student has the releasing authority.
* Signature and copy of identification required.