

AUTHORIZATION TO RELEASE RECORDS

This form must be <u>fully</u> completed. Please Print or Type

REQUEST FOR PUPIL RECORDS

I hereby authorize: Name of last school attended:			
Address:		Phone:	
		FAX:	
to release all records, including academic, discip	olinary, and Spe	ecial Education/504 records (if ap	plicable) of:
Student's Last Name	First Name Middle Name		
Student's Date of Birth:/ /	Student's Current Grade Level:		
The records are to be released for the purpose of O.C.G.A. § 20-2-670.	enrollment in	the Cobb County School District	and in compliance with
Signature of Parent/Guardian	Date	Signature of Student	Date
PLEASE SEND THE FOLLOWING RECOR	RDS TO:		
School: North Cobb High School	6		
Address: 3400 Highway 293 North		Phone: 770-975-8865	
77			8
Cumulative Record Report Card Immunization Record Test Data Discipline Record Special Education/504 Records Name of School Official Requesting Records (P)	lease Print)		
Signature of School Official Requesting Records	3	Title	

