TWIN CITIES ACADEMY

CONSENT TO RELEASE PRIVATE DATA

Student: _____Student ID:_____Grade:_____ Date:_____

Parent/Guardian Name: _____
Parent/Guardian Address:_____

Authorization:

I authorize_____TCA Staff_____of Twin Cities Academy located at 690 Birmingham St., St. Paul, MN, 55106.

- ☐ To release information to
- ☐ To obtain information from

Name:_____ Title:_____
Phone Number:_____
Organization:_____
Address:_____City:_____ State:_____ Zip:_____

The information to be related:

- ☐ Official School Records (e.g. name, address, DOB, gender, attendance record, grades, test results, etc)
- ☐ Health Record
- ☐ Psychological Records
- ☐ Special Education Results (including related services)
- ☐ Teachers, Counselor, Staff
- ☐ Chemical Abuse/Dependency Report
- ☐ Medical Report (including related services)
- ☐ Psychiatric Report
- ☐ Social Work Report
- ☐ Observations
- ☐ Other:_____

I understand that student records may be examined by parent/guardian(s) or the student if age 18 or older. I understand that this authorization takes effect the day it is signed. I understand that I may change or revoke this authorization at any time.

This authorization expires on _____ or no more than one year from the date of signature.

_____ _____
(Parent/Guardian Signature or Student if age 18 or older) (Signature Date)