Student Support Services Department
PO Box 2098
Everett, WA 98213
www.everettsd.org

REQUEST FOR EXCHANGE OF CONFIDENTIAL EDUCATIONAL INFORMATION

Date:

Student Name: Student ID: Birthdate:

Requestor: Name: School: Grade:

I hereby authorize the exchange of confidential information regarding the above named student:

Everett Public Schools and Address Phone: Fax:

Information Requested (check all that apply)

☐ Official Transcript ☐ Discipline Records ☐ Academic Records

☐ Health Records ☐ Educational Evaluations ☐ Immunization Records

☐ Special Education Records ☐ Social/Emotional/Discipline

☐ Psychological/Counseling

I acknowledge notification of this transfer of records as required by the Family Educational Right and Privacy Act of 1974 and understand that I have a right to receive a copy at my own expense if requested and have an opportunity for a hearing to challenge the content of the records. I understand that the information obtained will be treated in a confidential manner and will not be transmitted to a third party without my permission. I also understand that it is my right to request a copy of all information and contest any information I feel is incorrect. This authorization is valid until revoked in writing.

_____

Signature of Parent, Guardian, or Adult student Date

Relationship to Student:

Please return form/information to:

Requestor: Phone: Fax:

Address: