Laurel Highlands School District
304 Bailey Avenue
Uniontown, PA 15401
724-437-2821

AUTHORIZATION TO RELEASE SPECIAL EDUCATION RECORDS

Student's Name ______________________ Date of Birth ______________ Graduation Year ______________

Requestor's Name ______________________ Address ______________________

Home Telephone No. ______________ Cell Telephone No. ______________

I am hereby requesting Laurel Highlands School District to release the **original** Special Education file for the above-referenced student to the undersigned and understand by accepting this file, Laurel Highlands School District will no longer retain any documents on behalf of the student. I verify that I have authority to obtain these records.

Requestor is required to provide a copy of his/her driver's license.

Student's Signature: ____ Date: ____________

Requestor's Signature: ____ Date: ____________

(to be completed by Special Education Department)

DATE REQUEST PROCESSED: __________________ BY: ______________________________________

Date and Time Requestor was notified request was completed: ____

(to be completed at the time of pick up)

I acknowledge receipt of the original Special Education documents for the above-referenced student.

Name ____ Date Records Received ______________________

Relationship to Student ____

Original Form kept by Special Education Department. ***Copy provided to Student.***