Learning to Live • Loving to Learn

ACPS

Alexandria City Public Schools

PARENT CONSENT FOR RELEASE OF INFORMATION

STUDENT NAME: _____

SCHOOL: _____

I authorize the following individual or organization to disclose my child's academic records as described below:

Information to be received by:	*Information to be released by:*
_____ Name of Professional or Agency _____ Address _____ Phone _____ Fax _____ Signature	Shanna Samson Office of Partnerships and Community Engagement Alexandria City Public Schools 1340 Braddock Place Alexandria, VA 22314 (703) 619-8152 shanna.samson@acps.k12.va.us _____ Signature

I confirm that information and communication may be exchanged between parties for the purpose of developing student goals for improvement in the following areas:

___ Academic Progress

- SOL Scores
- Select Standardized Tests
- Reading/Math Levels
- Division Common Assessments (CRTs)
- Grades

___ Other (Please specify) _____

I consent to the release of the above information. I understand that use of this information for any reason other than the expressed reason stated above is prohibited and that disclosure of information to other parties is strictly prohibited. This consent is subject to revocation at any time.
My authorization will remain in effect for the entire academic school year 20__-__

I completed this form because I am: (please check one) ___ Parent ___ Legal Guardian

_____ _____

(SIGNATURE OF PARENT/LEGAL GUARDIAN) (DATE)