

STUDENT EDUCATION RECORDS RELEASE REQUEST

Request Date: _____

NAME OF SCHOOL: _____

Elementary

High School

STUDENT'S NAME: _____ DATE OF BIRTH: _____
(please include name while attending school)

YEAR OF GRADUATION, WITHDRAWAL OR TRANSFER: _____

RECORD REQUESTED: Transcript Cumulative Card Other: _____

REQUESTOR: _____

ADDRESS: _____

CITY, STATE, ZIP: _____

TELEPHONE NUMBER: _____ E-MAIL ADDRESS: _____

I agree to hold harmless the Diocese of Baton Rouge, the Roman Catholic Church, its subordinate Parishes, Bishops, clergy, and their successors in office, the aforesaid school and all other persons and institutions connected with them from any liability for releasing this information pursuant to my request.

SIGNATURE OF AUTHORIZATION: _____

*Note: The person authorizing release must be the person named in the record or the parent of a minor child. Anyone else must show proof of power-of-attorney.

SEND RECORDS TO

To me at the address above

To the address(es) listed below

Will pick up

Name & Address

Name & Address

RETURN THIS FORM ALONG WITH A COPY OF PHOTO IDENTIFICATION TO:

Diocese of Baton Rouge
Department of Archives
P. O. Box 2028
Baton Rouge, LA 70821-2028

Phone: 225-387-0561
Fax: 225-612-9285
e-mail: archives@diobr.org