Delaware Public Archives
...your window to the past!

PERMISSION FOR DISCLOSURE OF EDUCATIONAL RECORDS

Name of Student while attending school (use legal last name):

_____

Date of Birth: _____

School/Attended: _____

Daytime Telephone Number: _____

Current Address: _____

Permission is granted to disclose the education records listed below:

Year Graduated _____ or Year Withdrawn _____

Please check appropriate items:

1. _____ Cumulative record (i.e., academic grades, attendance date, and test scores)
2. _____ Health data and / or medical reports.
3. _____ Diagnostic and evaluative data
4. _____ Other (be specific) _____

The record(s) indicated above is/are to be disclosed to: _____

Street _____

_____

City, State, Zip _____

The Purpose for this disclosure is: _____

I hereby consent to the disclosure of the above record(s).

Date: _____ Signature: _____

(Parent/guardian/student over 18 years)

Mail to:
Delaware Public Archives
121 Martin Luther King Jr. Blvd. North
Dover, DE 19901

Attn: Records Management Specialist
Telephone: (302) 744-5004
Fax: (302) 739-6710
Email: rrecords@state.de.us

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