

# The MARSHALL School



## Authorization to Request / Release Student Records

To: \_\_\_\_\_ (School Name)  
 \_\_\_\_\_ (Address)  
 \_\_\_\_\_ (City, State ZIP)  
 \_\_\_\_\_ (Phone Number)

I request that all records listed below for

\_\_\_\_\_ *Last*                      \_\_\_\_\_ *First*                      \_\_\_\_\_ *MI*  
 \_\_\_\_\_ *Date of Birth*                      \_\_\_\_\_ *Grade*

be sent to:

**The Marshall School  
 810 Westwood Office Park  
 Fredericksburg, VA 22401  
 TEL: (540) 368-1960  
 FAX: (540) 368-1966**

Records include:

_____ Academic Records - attendance - transcripts	_____ Test Records - standardized test results
_____ Health Records - immunization record	_____ Confidential Records - All Special Education Records
_____ Other	

\_\_\_\_\_ *Parent or Guardian's Signature*

\_\_\_\_\_ *Date*

\_\_\_\_\_ *Parent or Guardian's Printed Name*