Uniontown Area School District
205 Wilson Avenue
Uniontown, PA 15401
724-438-4501

AUTHORIZATION TO RELEASE SPECIAL EDUCATION RECORDS

Student's Name _____ Date of Birth _____ Graduation Year _____

Requestor's Name _____ Address _____

Home Phone _____ Cell Phone _____

I am hereby requesting Uniontown Area School District to release the **original** Special Education file for the above referenced student to the undersigned and understand by accepting this file, Uniontown Area 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: _____

This section is to be completed by the 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.

_____ _____
Signature Date Records Received

_____
Relationship to Student

Original Release form kept by Special Education Department *Copy provided to student*