

RELEASE OF RECORDS FORM

REQUEST FOR STUDENT RECORDS

I, the undersigned parent/guardian of

(Printed Name of Student)

do hereby authorize

Name of last school attended:

Phone Number

Fax Number

Street, City, State, Zip Code

Contact Person

to release cumulative records-

- transcripts
- immunization, health, vision & hearing
- test results
- psychological evaluation
- behavioral information
- other necessary records for academic assessment

**Records to be sent to: Atholton Adventist Academy
Admission's Office
6520 Martin Road
Columbia, MD 21044**

Signed: _____
Parent/Guardian Date

Atholton Adventist Academy

FOR OFFICIAL USE ONLY

Date Faxed/Mailed: _____ Date Record Received: _____

Phone: 410-740-2425

Fax: 410-740-2545

office@atholton.us