

Montcalm Schools
AUTHORIZATION TO RELEASE/OBTAIN INFORMATION

Name

Date of Birth

Street Address

City

State

Zip

I hereby authorize Montcalm Schools to release/obtain the following information:

to:

Name of the organization to which disclosure is to be made

Phone

Contact person at this organization to which information is to be sent

Fax

Street Address

City

State

Zip

This information is to be used for the following purposes:

I understand that this consent expires in 90 days unless previously revoked by me in writing.

Signature

Date

Signature of Parent/Guardian if under 18

Date

Fax completed form to Starr Commonwealth 517.629.2317 or mail to Records Manager, Starr Commonwealth, 13725 Starr Commonwealth Road, Albion, MI 49224.