Woodridge Local School District

REQUEST FOR RELEASE OR TRANSFER OF PSYCHOLOGICAL OR COUNSELING RECORDS

It is requested than an official copy of all records of:

Name _____

Address _____

School _____

Parents _____

be released, as soon as possible, to:

_____
Signature of Parent/Legal Guardian

_____ all testing

_____ recommendations

_____ observations

_____ pertinent data

_____ medical information

Thank you for your consideration in this matter.

Sincerely,