



DCPS Authorization for Release of Education Records – Adult Student or Former Student

I _____ hereby give
(Student's Name and date of birth)

consent to the appropriate official at my current school, former school, or the DCPS Office of Data and Strategy to release my education records to:

(Name of representative agency, physician, or attorney)

(Address and phone number of representative agency, physician, or attorney)

The purpose of the disclosure is

(Describe the specific purpose for the records disclosure)

By signing below, I authorize the release of the following records:

I am 18 years of age or older and have the right to challenge the contents of such records.
NOTE: This release is valid only for the purpose stated. The DCPS may

(Former Student Signature)

(Former Student Current address)