NORTHWEST ARCTIC BOROUGH SCHOOL DISTRICT

Ambler · Buckland · Deering · Kiana · Kivalina · Kobuk · Kotzebue · Noatak · Noorvik · Selawik · Shungnak
PO Box 51 · Kotzebue, Alaska 99752 · Phone (907) 442-1800

CONSENT TO RELEASE EDUCATION RECORDS

Please fax this form to 888-965-6526 or scan and email it to registrar@nwarctic.org

The Family Educational Rights and Privacy Act (FERPA) is a federal law that protects the privacy of student education records. By completing this form, I hereby consent to the release of the education records specified below. I further authorize the person or entity authorized to release the education records to discuss this information with the persons or representatives of the organization identified below to which the records are to be released:

Name of student:____Birthdate:______________________

Name of school:______________________________Graduation date or last attended:______________________

Please release and deliver records from these (please check the appropriate box(es))

☐ Northwest Arctic Borough School District

☐ Other (please specify):____

Please check all records you wish to have released:

______Grades/Transcripts ______Attendance ______School Health Records

______Special Education Records ______Psychological & Counseling ______Disciplinary/Suspension

______All education records ______Other:____

This information is to be disclosed and used for:

______Special Education Evaluation and Planning ______§ 504 Evaluation and Planning

______Provision of Education Services ______School Nursing

______Other:____

Person requesting records to be released	Records to be released to
Your Name:	Name:
Relationship to Student:	Address:
Address:	City, State, Zip Code:
City, State, Zip Code:	Telephone Number:
Telephone Number	

I understand that by consenting to the release of the above-specified education records, the party to whom those records will be released is not to permit any other party to have access to those records without my written consent, unless required by law. I further understand that upon my request, it is my right to have a copy of the records to be released.

Please Initial: I _______**DO** or ________ **DO NOT** request a copy of such records.

This consent to release information is effective for one year from the date signed, unless sooner revoked in writing. A copy this consent is to be as effective and valid as the original signed by me.

Signed:____Date:______________________________
Signature of Parent/Guardian or Student if at least 18 years of age