AUTHORIZATION FOR RELEASE OF CONFIDENTIAL INFORMATION

Student Legal Name: ____ Date: _______________

School District: Hoonah City Schools

District Address: P.O. Box 157, 355 Garteeni Highway

Hoonah, Ak 99829

As parent/guardian of the student, I hereby authorize the release of confidential information between the School District and: ____
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I understand that the information will be treated in a confidential manner. I also understand that is my right to request a copy of all information and can contest any information I feel is incorrect.

Parent/Guardian Signature: ____

Address: ____
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