



Immaculate Conception Catholic School

AUTHORIZATION FOR RELEASE OF CONFIDENTIAL STUDENT RECORDS

I authorize the transfer of all records pertaining to _____
Name of Student Grade

School transferring from _____

Address _____
City State Zip

I understand I may request, from the above authorized school, a copy of the records to be transferred, if desired.

Signature of parent, guardian or student (if of age)

Date Signed

Scan records to: **info@icsnlr.org**
Immaculate Conception Catholic School
7000 JFK Blvd
North Little Rock, AR 72116
501.835.0771