REQUEST FOR TRANSFER OF RECORDS
AND
AUTHORIZATION FOR MUTUAL EXCHANGE OF CONFIDENTIAL INFORMATION

Please send all student records including immunization records and special program records (special education, etc.) for the following student(s):

Student Name	Date of Birth	Special Program	Grade
1.			
2.			
3.			
4.			
5.			
6.			
7.			

From:

School District	
Address	
Phone FAX	

Mail to:

Davenport Elementary School
601 Washington Street
Davenport, WA 99122
Phone: (509) 725-1261
FAX: (509) 725-2780

Davenport Middle School
601 Washington Street
Davenport, WA 99122
Phone: (509) 725-0766
FAX: (509) 725-2780

Davenport High School
801 7th Street
Davenport, WA 99122
Phone: (509) 725-4021
FAX: (509) 725-2260

I acknowledge notification of this transfer of records as required by the Family Educational Rights and Privacy Act of 1974 and understand that I have a right to receive a copy at my own expense, if requested, and have an opportunity for a hearing to challenge the content of the records. I understand that the information transferred will not be transmitted to a third party without my consent.

Parent Signature:		Date:
School Official Signature:	Title	Date