



AURORA CENTER FOR HEALING
RELEASE OF STUDENT SCHOOL RECORDS
Exhibit D

	REQUESTING SCHOOL	SENDING SCHOOL
SCHOOL	AURORA CENTER FOR HEALING	
STREET ADDRESS/PO BOX	PO BOX 914	
CITY	HAWTHORNE	
STATE, ZIP	NEVADA, 89415	
PHONE NUMBER	801-616-7064	
FAX NUMBER		

Student Name

Date of Birth

SSN

Does this student have an active IEP? ___Yes ___No

The Aurora Center For Healing hereby requests the release of education records for the student identified above who recently enrolled in Aurora Center For Healing in the _____ grade. I hereby request the release of the following school records to be sent to Aurora Center For Healing:

_____/____ Initials

1. Transcripts
2. Withdrawal Grades (include any incomplete classes, if applicable)
3. Special Education Records (include any counseling information)
4. Any additional information which would be of assistance in placing this student.

Dated: _____

Signature of Authorized Aurora Center For Healing Representative:

Aurora Center For Healing Representative Position:

☐ Parent/Guardian (Sponsor) Signature:

☐ Parent/Guardian (Sponsor) Print Name:

Date: _____

____/____ Initials