AUTHORIZATION TO RELEASE PERSONAL INFORMATION

The signature on this form authorizes the release of personal information by the Hawaii State Department of Education. Also include a signed photo ID with request.

Date of Request _____

Reason for Request _____

Legal Name _____

Other Name(s) Used _____

Date of Birth _____

Social Security Number _____

Phone Number _____

Tested While in the Military _____

Name of School/Test Center _____

Year Tests Completed _____

Former high school(s) _____

City or town of residence _____

Send Verification to:

Name _____

Address _____

City/State/Zip Code _____

Fax _____

Phone _____

In accordance with the Family Educational Rights and Privacy Act of 1974, the requestor's academic information is classified and confidential and will be released only with the requestor's written authorization and signature and only to the specific party and for the specific purposes as determined by the requestor. I certify that I am the person whose name appears on this form, and do hereby authorize the release of my academic information.

Print Full Legal Name of Authorized Requestor _____

Authorized Requestor's Signature _____