WESTFIELD AREA HIGH SCHOOL/MIDDLE SCHOOL

N7046 CTY ROAD M
WESTFIELD, WI 53964
PH: 608-296-2141 FAX: 608-296-2293

DAVID MOODY – PRINCIPAL
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ANDREW SALOUN – VICE PRINCIPAL
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JEFF STECKBAUER – ATHLETIC DIRECTOR
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Transcript Request

Student's Name at time of Graduation_____

Birth Date_____Graduation Year _____

Address_____City, State and Zip_____

Home Phone_____Work Phone_____

School District to Release Information:

High School Westfield Area High School

Attn: Erin Stampfl, Registrar

Address N7046 Cty Rd M

City, State, Zip Westfield, WI 53964

Phone Number: 608-296-2141

Fax Number: 608-296-2293

School District/ Agency to Obtain Information:

School _____

Attn: _____

Address _____

City, State, Zip _____

Phone Number: _____

Fax Number: _____

I hereby authorize the above named individuals/agencies to release and/or obtain from one another the following written and/or verbal information/records, unless otherwise specified:

- ❑ Official student academic/administrative records (identifying information, grade level completed, grades, class rank, attendance records, group aptitude and achievement test results)-Transcript
- ❑ Other:_____

I certify that I am the above named student or legal guardian of the above named student and have the authority to sign this release.

_____ _____

Signature of Student Date

Your Rights with Respect to this Authorization:
Right to Inspect or Copy the Health Information to be Used or Disclosed: I understand that I have the right to inspect or copy the health information I have authorize to be used or disclosed by this authorization form. I may arrange to inspect my health information by contacting my health care provider who is releasing the records. Right to Receive a Copy of this Authorization: I understand that if I agree to sign this authorization, I will be provided a copy of it if requested. Right to Revoke this Authorization: I understand written notification is necessary to cancel this authorization. To obtain information on how to withdraw my authorization or to receive a copy of my withdrawal, I may contact the School District of Westfield. I am aware that my withdrawal will not be effective as to uses and/or disclosure of my health information that the person(s) and/or organization(s) listed above have already made in reference to this authorization. A copy or fax of this authorization shall be considered as valid as the original. Expiration Date: This authorization is in effect for one year from the date signed unless revoked in writing.

Re-disclosure Notice: Any health information used or disclosed based on this information may be subject to re-disclosure by school officials and may no longer be protected by HIPPA privacy rules.