

Plattsburgh City School District

AUTHORIZATION TO RELEASE OFFICIAL STUDENT TRANSCRIPT or IMMUNIZATION RECORDS

All fields must be completed and signed form must be received before transcript will be released.
Incomplete forms will not be honored.

Please print all information clearly and accurately.

Personal Information:

Name: _____ SSN: (last four #'s) _____

If attended under a different name, print name here: _____

Phone number: _____ DOB: ____/____/____

Date last attended: _____ Graduated from PHS: Yes ____ No ____

This request is for ____ Official Transcript ____ Immunization record

Please print the address or Fax number to which you would like a copy of your records sent.

_____	_____
_____	_____
_____	_____
_____	_____

Please read and sign below:

By signing this form, I authorize the Plattsburgh City School District to release my official transcript or immunization record. I also certify that the record I am requesting to be released is my own. I further understand that if I sign for another individual's record to be released, I agree to be held liable.

STUDENT SIGNATURE: _____ DATE: _____

If your date of birth is 1994 or after

Email to grose@plattscsd.org
Or: Mail the completed form to:

Plattsburgh High School
1 Clifford Drive
Plattsburgh, NY 12901

If your date of birth is 1993 or earlier

Email to lwang@plattscsd.org
or Mail the completed form to:

Plattsburgh City School District
49 Broad Street
Plattsburgh, NY 12901