BARRINGTON CHRISTIAN ACADEMY

Release of Records

I, _____, give my permission to

_____
School Name

_____
Street

_____
City *State* *Zip*

_____
School Phone Number *School Fax Number*

to release the academic and medical records of my child,

_____
Student's Full Name *Date of Birth*

and send them to:

Admissions Office
Barrington Christian Academy
9 Old County Road
Barrington, RI 02806

It is my understanding that the recipient of these records will treat them with complete confidentiality.

_____ _____
Signature (Parent/Guardian) *Relationship to Student*

_____ _____
Full Name *Email Address*