Central Bucks High School South

Release of Records Authorization
Student/Parent Authorization

Student Name: ________________________________ Counselor: ____________________

Student's CBSD email: ______________________________________

Please initial the following:

______ I give permission to release the following to all colleges/universities, NCAA, scholarships, and enrichment programs, as needed:

Official Transcripts
Secondary School Report
Recommendations
Mid-year and final grades
School Profile

______ I am aware that all requests require 15 school days to process.

______ I am aware that if I ask for a counselor letter of recommendation I need to complete the Counselor Letter of Recommendation Survey in Naviance. ***Failure to do so will result in a delay in my transcript submission.***

______ I acknowledge that counselor and teacher letters of recommendation and Secondary School Reports are confidential, personal in nature, and are not part of my educational record. I hereby **waive my right** to view the letters of recommendation at any time.

Student Signature: _______________________________ Date:__________________

I authorize the release of records as described above.

Parent Signature: ________________________________ Date:__________________

For Office Use Only

Office Received:_____________ Processor Received: _____________