



**Diocese of Wheeling-Charleston  
STUDENT EDUCATION RECORDS RELEASE REQUEST**

Date: \_\_\_\_\_

NAME OF SCHOOL: \_\_\_\_\_ CITY: \_\_\_\_\_

TYPE OF SCHOOL:    Elementary                    High School

STUDENT'S NAME: \_\_\_\_\_ DATE OF BIRTH: \_\_\_\_\_  
(LAST, FIRST, M.I. -Please include name while attending school)

YEAR OF GRADUATION, WITHDRAWAL OR TRANSFER: \_\_\_\_\_

RECORD REQUESTED:    Transcript            Cumulative Card    Health            Other: \_\_\_\_\_

NAME OF REQUESTOR: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

CITY, STATE, ZIP: \_\_\_\_\_

PHONE NUMBER: \_\_\_\_\_ E-MAIL ADDRESS: \_\_\_\_\_

*I agree to hold harmless the Diocese of Wheeling-Charleston, its subordinate Parishes, Bishops, clergy, and their successors in office, the aforesaid school and all other persons and institutions connected with them from any liability for releasing this information pursuant to my request.*

SIGNATURE OF AUTHORIZATION: \_\_\_\_\_

**\*Note: The person authorizing release must be the person named in the record or the parent of a minor child. Anyone else must show proof of power-of-attorney.**

MAIL TO THE ADDRESS (ES) LISTED BELOW

Name & Address:	Name & Address:

RETURN THIS FORM ALONG WITH A COPY OF PHOTO IDENTIFICATION TO:

Diocese of Wheeling-Charleston  
Office of Archives & Records  
1300 Byron Street  
P. O. Box 230  
Wheeling, WV 26003