



# THE HIGHLANDS SCHOOL

Discover Yourself. Achieve Success. Inspire the World.

## Authorization To Release Records

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

Student's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

\_\_\_\_\_  
Name of school **from** whom records are being requested

\_\_\_\_\_  
Address of school

\_\_\_\_\_  
Email Address of school representative

Please send the most current/final reports, medical records and immunization records for this student to:

**By Mail:** The Highlands School  
2409 Creswell Road  
Bel Air, Md. 21015

**By FAX:** Attn: Admissions Department  
443-412-1098

**By Email:** [slippa@highlandsschool.net](mailto:slippa@highlandsschool.net)

This information should include all available educational, health, psychological and achievement testing. Your assistance is appreciated.

\_\_\_\_\_  
Parent authorization of records release

\_\_\_\_\_  
Highlands School Authorized Signature