

SCHOOL CITY OF HAMMOND – Central Files
Consent for Release of Information

I hereby give consent for the SCH to release information about: _____
(Print Students Name)

Date of Birth: _____ Year of Grad / School/ Misc. _____

Reason: _____

Address: _____

Phone: _____ Soc. Sec. Number: _____

Requested By: _____ Relationship: _____

Signature: _____ Date: _____

Email address: _____

*By signing consent form you are granting permission for the School City of Hammond Central Files Office to email a copy of your school records to the email address provided. **Please return to the mailing address below along with a photocopy of your ID***

Transcript \$5.00 Fee (Cash or Money Order)

Health Records \$1.00 Fee (Cash or Money Order)

Request for Student Records \$0.10 per page (Cash or Money Order)

Money Order should be made out to: School City of Hammond

Please complete, sign, and return along with fee to the following address:

School City of Hammond, Central Files, 41 Williams Street, Hammond, IN 46320

Upon receipt we will issue an official transcript or health record as requested.

Any questions, please call (219) 933-2400 ext. 1035, 1087 or 1039.