

# AUTHORIZATION TO RELEASE SCHOOL TRANSCRIPT

Authorization is hereby granted to Forsyth Public Schools to release permanent transcript records of:

\_\_\_\_\_  
Full Name at time of graduation (Please print or type)

\_\_\_\_\_  
Year of graduation from Forsyth High School

**Please release the records to the following address:**

\_\_\_\_\_  
Name

\_\_\_\_\_  
Complete Mailing Address

\_\_\_\_\_  
City

\_\_\_\_\_  
State

\_\_\_\_\_  
Zip

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature

**RETURN SIGNED FORM TO:**

Forsyth High School  
Box 319  
Forsyth, MT 59327  
FAX: 406-346-9219  
EMAIL: gsorenson@forsyth.k12.mt.us  
sweight@forsyth.k12.mt.us

**FOR OFFICE USE ONLY:**

Transcript sent on \_\_\_\_\_  
Date

By: \_\_\_\_\_  
Authorized Name or Initials