Authorization for the use and disclosure of Protected Information

Student Name____Date of Birth______________

Parent or Guardian Name (if not being requested by the student 18 or older)

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I hereby authorize Gersh Academy to disclose protected health or education information about me in accordance with the following terms and conditions:

Please check the description of information to be disclosed:

Educational Records___

Related Services or Behavioral Information___

Individuals or entities to whom the information may be disclosed:

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Signature

____

Date

Forms should be downloaded and signed by hand, then emailed to:
StudentRecords@GershAcademy.org