***BLANK ADVENTIST ACADEMY***

**Authorization for Release of Records**

Students Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I hereby authorize:

(School & Address) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

to release my cumulative record folder.

Please mail my records to:

**Registrar**

**Blank Adventist Academy**

**1000 Academy Drive**

**Happy Valley, CA 77777**

This release is for the purpose of educational planning. This is to notify you of your right to receive a copy of the record and a right to a hearing to challenge the contents.

**Medical Restrictions**: I understand that requestor may not further disclose medical information unless another authorization is obtained from me or unless such use or disclosure is specifically required or permitted by law.

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*Parent/Legal Guardian (printed) Parent/Legal Guardian Signature Date*