Gloucester City
Public Schools

1300 Market Street

Gloucester City, NJ 08030

Authorization for Release of Information

To: _____

_____

_____

Student's Name_____

Date of Birth _____

Grade_____

Parents' Names _____

_____

To Whom It May Concern:

I hereby authorize the release of records including medical, psychological, educational and/or social information from the reports and records of the above child to the professional personnel of the Gloucester City Public School District. Such information is to be used for the completion of records to aid in the proper school placement and planning for the child.

Sincerely,

_____

Signature of Parent/Guardian