FRANK J. COCUZZA, MSW
DIRECTOR

LAUREN NAVA, M.Ed.
PRINCIPAL

AUTHORIZATION FOR THE RELEASE OF INFORMATION

I, _____ hereby authorize
(Name of Parent/Guardian)

_____
(Shepard Personnel)
Shepard Schools, 8 Columba St. Morristown, NJ 07960 and 2 Miller Rd. Kinnelon, NJ 07405

to release medical, psychological, psychiatric, education, or other information regarding:

_____
(Name of Student)

_____
(Date of Birth)

To:_____
_____
_____

Purposes for which this information is to be used:_____
_____
_____
_____

Specific information to be released:_____
_____
_____
_____

This authorization shall become effective immediately and shall be valid until the date of: _____

I understand that medical/psychiatric/educational information is to be released only to the above named party or agency and may not be further disclosed, except where specifically required or permitted by law, without additional authorization.

_____ _____
Parent/Guardian Signature Date