Desmond T. Doss Christian Academy

19 George Street • Lynchburg, VA 24502 • phone: 434-237-1899 • fax: 434-237-0820

Authorization to Release/Obtain/Share Information

Student's Name:_____ Parent/Guardian_____

I hereby authorize Desmond Doss Christian Academy to receive and give information concerning my student. I also authorize my student's physicians, educators, and others who may possess confidential information concerning my student to divulge and deliver that information to Desmond Doss Christian Academy. Should I, at any time, wish to retain the con confidential nature of any such information; I will advise you in writing.

Parent or Guardian Signature_____ Date Signed_____

1: Agency/Person_____ Email_____ Phone_____

Street_____ City_____ State____ Zip_____ Fax_____

2: Agency/Person_____ Email_____ Phone_____

Street_____ City_____ State____ Zip_____ Fax_____

WE REQUEST THE FOLLOWING RECORDS:

◯	All records
◯	Grade Transcript or report card
◯	Mental ability test results
◯	Achievement test results
◯	Health record
◯	Clinical test results
◯	Other: _____

Authorized by:

_____

Parent or Guardian Signature

Please save your completed form to your hard drive, then email it to info@desmondtdoss.org.
NOTE: Be sure you attach the completed PDF form(s) to your email before you hit *Send*.