



SIGNATURE HEALTHCARE

Brockton Hospital School of Nursing

BROCKTON HOSPITAL SCHOOL OF NURSING PERMISSION TO DISCLOSE INFORMATION FORM

The Family Education Rights and Privacy Act (FERPA) of 1974 is designed to protect the privacy of a student's education records. These confidential records include financial aid, scholarship and billing/account information, and will not be released without written consent from the student. By signing this form, the student authorizes Brockton Hospital School of Nursing personnel to release confidential information to designated person(s).

STUDENT NAME: _____
(please print)

ANTICIPATED GRADUATION DATE: _____

I authorize the Brockton Hospital School of Nursing Registrar's Office, Student Financial Aid Office and Office of the Bursar to release confidential student educational records/account information to the person(s) listed on this form. _____ (please initial here)

I **decline to** authorize the Brockton Hospital School of Nursing Registrar's Office, Student Financial Aid Office and Office of the Bursar to release confidential student educational records/account information
_____ (please initial here)

I understand that the person(s) listed on this form will have access via telephone, in person, or mail to the information that may include the following:

- My financial aid and scholarship records, including processing and eligibility status as well as award types and amounts.
- My tuition billing account and statements, including credits and debits posted to that account and any refund amounts I may have received.
- My educational records including enrollment status, grades, G.P.A. and if applicable transfer credits.

Name(s) of people to release information to: (please print)

Authorization Password: _____

Please limit the password to one printed word. The authorized person(s) will be expected to know this information.

This authorization will remain in effect until revoked in writing by the student.

STUDENT SIGNATURE: _____

DATE: _____