Bishop Dunn Memorial School
50 Gidney Avenue
Newburgh, NY 12550
phone: (845) 569-3494
fax: (845) 569-3303

Release of Record Form

Date: _____

Student Name: _____

I hereby authorize:

_____
(Name of School Student is Currently Attending)

_____
(Street Address)

_____
(City) **(State)** **(Zip)**

To forward all academic and medical records to:

Bishop Dunn Memorial School
50 Gidney Avenue
Newburgh, NY 12550
Attn: Melissa Broe
Melissa.broe@bdms.org

It is my understanding that these records are for professional use and will be kept in a confidential file.

Signed: _____ **Date:** _____
(Parent or Guardian)