Financial Aid & Student Accounts
Authorization to Release Information

Reading Hospital School of Health Sciences is committed to protecting the rights of students who are attending or who have attended the school. The Family Educational Rights and Privacy Act (FERPA), is a federal law designed to protect the privacy of a student's educational records.

Education records are all records that contain information directly related to a student and are maintained by an educational agency or institution or by a party acting for the agency or institution. All FERPA rights transfer from the parent to the student when a student attends a postsecondary institution - regardless of parental information that may have been required when applying for financial aid. Therefore, Financial Aid and Student Accounts Office employees are unable to discuss matters with members of the student's family or other persons without the express written consent from the student. If applicable, please complete this form and return it to the Financial Aid Office so your file can be notated accordingly.

In accordance with the Family Educational Rights and Privacy Act, I authorize the release of my financial information to the individual(s) named below:

Students Name Providing Authorization:_______________________________________ Student ID:____________

Last 4 Digits of Social Security:__________________ DOB:______________________ Program:______________

Individual to Receive Information	Relationship	Email Address	Phone Number

Note: Please create your **password** (no symbols or special characters please) and be sure to inform the individual(s) listed above what your password is. When calling in, the authorized individual(s) will be asked to provide the password on your account. No information will be shared if the password given is incorrect.

Account Password:_______________________________________ (ex. pet's name, favorite food, etc.)

I understand that this authorization for release of my financial information will remain in effect until I graduate, withdraw, terminate or I personally request from RHSHS in writing that this authorization be nullified or changed.

Student Signature:_______________________________________ Date:________________

Return Form to:	Reading Hospital School of Health Sciences Financial Aid Department PO Box 16052 Reading, PA 19612 6052	Or Fax to: 484 628 0134 Questions: 484 628 0106