

AUTHORIZATION FOR RELEASE OF INFORMATION

Name of Student (Last Name, First Name)

Date of Birth

Consent for FULL Access to Educational Records:
(Full access does not give authority to make changes
to the student's educational record).

Consent for LIMITED Access to Educational Records:
(Limited access does not give authority to make changes
to the students educational record).

For the following specific information or records :

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 One Time Use: This authorization can be used only once

Long Term Use: This authorization will remain continuously in effect until I withdraw this authorization in writing or until
the end of this current school year (end of Summer term).

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Purpose for the authorization for release of information: _____

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Name and address of Individual or Agency to whom access to records may be provided:

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I understand that some of my records may be protected under the Family Educational Rights and Privacy Act of 1974 and
cannot be released without my written consent. I hereby waive all provisions of the law and privilege relating to the records
described in this disclosure. I certify that this consent has been given freely and voluntarily. I may revoke this consent at any
time by providing written notice of such revocation to the University office or person who maintains the records of this
authorization. This authorization is good until the end of this current school year (end of Summer term) during which the
authorization is signed, unless noted differently above, and photocopies of this release form may be accepted, when
presented in person with appropriate identification. The person and/or agency receiving this information may not disclose
the information received as a result of this disclosure unless specifically authorized in the "purpose" section of this release.
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Student Signature: _____

Date: _____