



Authorization for Release of Information

Date	Name of Student (Last, First, Middle Initial)	Student ID Number

<p>Consent for Full Access to Educational records: (Full access does not give authority to make changes to the student’s educational record).</p>	<p>Consent for LIMITED ACCESS to Educational Records: (Limited access does not give authority to make changes to the student’s educational record).</p> <p>Only my University transcript</p> <p>Only the following specific information of records:</p>
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One Time Use: This authorization can be used only once:

Limited Use: This authorization expires on _____

Long Term Use: This authorization will remain continuously in effect until I withdraw this authorization in writing or for a maximum of one year.

PURPOSE FOR THE AUTHORIZATION FOR RELEASE OF INFORMATION:

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

Address of Individual or Agency:

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 Registrar’s Office. This authorization is good for one year from the date I sign this release, 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.

Student Signature _____ Date: _____