

# STETSON UNIVERSITY

## Authorization and Consent to Release Education Records

The *Family Educational Rights and Privacy Act of 1974 (FERPA)*, as amended, is a federal law that protects the privacy of student education records. By completing this authorization and consent form, a student may grant permission to authorized personnel of the University to release some or all of their education records to a third party.

*Please note: This form does not allow the release of Medical Information. A separate form for release of medical information is available with the Health Services Office.*

I authorize \_\_\_\_\_ (Office/Department/School) of Stetson University to discuss or release the following information to the person(s) identified below:

- \_\_\_\_\_ Academic Records (transcript, grades, GPA)
- \_\_\_\_\_ Advising records
- \_\_\_\_\_ Student Account and Billing Records
- \_\_\_\_\_ Financial Aid Records (grants, loans, scholarships)
- \_\_\_\_\_ Student Affairs Records (housing, conduct/disciplinary)
- \_\_\_\_\_ Other (specify) \_\_\_\_\_

### Persons authorized to receive these records:

Name: \_\_\_\_\_  
Email: \_\_\_\_\_  
Address: \_\_\_\_\_  
Telephone#: \_\_\_\_\_  
For the Purpose of: \_\_\_\_\_

Name: \_\_\_\_\_  
Email: \_\_\_\_\_  
Address: \_\_\_\_\_  
Telephone#: \_\_\_\_\_  
For the Purpose of: \_\_\_\_\_

**By my signature, I acknowledge this consent and authorization to be valid. I understand that this consent remains in effect until written revocation from me is received by the above mentioned off/department/school. I also understand that such revocation does not affect disclosures previously made.**

Student Name (print) \_\_\_\_\_  
Signature \_\_\_\_\_  
Student ID number \_\_\_\_\_  
Date \_\_\_\_\_

*Note: Form must be filed by the student with the office/department/school that is being requested to share information with a third party as noted above.*