

Authorization to Release Education Records –Adult Student or Former Student

I _____ hereby give consent to the appropriate official at my
(Student’s Name and date of birth)

current school or former school, _____ to release my education records to:

(Name of representative, agency, physician, or attorney)

(Address and phone number of representative, agency, physician, or attorney)

The purpose of the disclosure is:

_____.

(Describe the specific purpose for the records disclosure)

By signing below, I authorize the release of the following records:

_____.

(Describe specifically which records are to be released including any applicable date range)

By signing below, **1) I acknowledge and understand that I have the opportunity to review the records to be disclosed and the right to challenge the contents of such records; and 2) I am 18 years of age.**

NOTE: This release is valid only for the purpose stated. The sending school must obtain my written authorization before releasing any further information to any other requester. **This authorization will expire one year from the date of signature.**

(Adult/ Former Student’s Name-Printed)

(Adult/ Former Student’s Signature)

(Adult/ Former Student’s Current Address)

(Adult/ Former Student’s Contact Number)

(Date)