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Authorization for Release of Information

DATE: _____

STUDENT ID: _____ DATE OF BIRTH: _____
STREET ADDRESS: _____
CITY: _____ STATE: _____ ZIP: _____
TELEPHONE NUMBER: _____

I, _____, authorize The University of Akron to release my conduct records, to the following individuals or organizations (name & address of persons/organizations to receive information)

_____
for the purpose of _____.

Confidentiality of academic records is protected by the Family Educational Rights and Privacy Act. To the extent it is applicable, FERPA may protect the records being released pursuant to this request. Any person/facility receiving authorized information may not further disclose such information without the written consent of the person to whom it pertains.

I understand that I can revoke this authorization at any time by providing written notice to the person/facility to whom I have instructed to release the information. I understand also that any information released prior to revocation cannot be retrieved and neither the person/facility releasing, nor the person/facility receiving the information will be held responsible for such.

I hereby release The University of Akron, and its employees and agents from all legal responsibilities or liability that may arise from this act.

Release Authorized By:

_____
STUDENT SIGNATURE

_____
Date

Witnessed By:

_____
WITNESS SIGNATURE

_____
Date

NOT VALID AFTER ONE CALENDAR YEAR FROM DATE OF ISSUANCE.