UNIVERSITY OF ST. AUGUSTINE
FOR HEALTH SCIENCES

FERPA Student Authorization Release Form

I understand that under the provision of the Family Educational Rights and Privacy Act (FERPA), as amended, my records at the University of St. Augustine for Health Sciences will not be released to a third party without my approval. I hereby give permission to authorized personnel at the University to release these records upon request: **Please check all that apply.**

__ **Academic Records (includes grade reports)**
__ **Financial Assistance**
__ **Student Development / Conduct**
__ **Student Accounts**
__ **Other (describe): _____**

Name of individual(s) to whom information may be released: (Please Print)

Name(s): _____
Relationship: _____
Address: _____
_____
Telephone: _____

__ **Please honor requests for my records by those individuals or parties identified above.** I acknowledge by my signature that I understand, although I am not required to release my records to the above individual(s), I am giving my consent to release the information. I understand that this release remains in effect until such time as I choose to revoke this permission in writing.

__ **Please revoke the FERPA Student Authorization Release Form on file at the University of St. Augustine for Health Sciences**

Student Name: _____

Student ID#: _____

Signature: _____

Date: _____

Return this form to: registrar@usa.edu