**FAMILY EDUCATIONAL RIGHTS AND PRIVACY ACT**

**AUTHORIZATION TO RELEASE INFORMATION**

Please complete this form and submit to the Haverford College office or department which is responsible for the record(s) that you identify below. By completing and signing this form, you are giving Haverford College permission to share information from you education records over which they control. If you are providing more than one office with authorization, a copy of this form should be provided to each.

**Student Name**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Student ID**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Student contact information (phone or email)**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Haverford College Office, department or individual to whom you are providing this authorization** **to release your information**:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Specify the Information to be released**:

**Purpose of release\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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**This consent is to remain in effect from \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_until\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_(specific dates)**

I certify that this consent has been given voluntarily, I may revoke this consent at any time prior to the above indicated date or at any time after signing this authorization by providing the office, department or individual noted above with written notice of my revocation of this authorization.

**Student signature**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_