FERPA
AUTHORIZATION TO RELEASE INFORMATION FROM ACADEMIC RECORDS

(*Required) Incomplete forms cannot be processed.
Please Print Clearly or Type All Information

TO BE COMPLETED BY STUDENT:
Pursuant to the provisions of the Family Educational Rights and Privacy Act of 1974, as amended (FERPA), I give my consent to authorized representatives of the University of Arkansas for Medical Sciences for the release of my academic records and any and all personally identifiable information contained therein to the below listed individual. I understand that this authorization will remain in effect until I rescind it in writing. I understand that I have the right to rescind this authorization at any time.

Student Information

Effective:(circle) Fall Spring Summer

Year:_____

_____
Student Name

_____
ID Number

_____
Student Signature Date

Identity of Person Authorized to Receive Academic Information

Relationship to Student:_____

_____
Name

_____
Address

_____
City State Zip

TO BE COMPLETED BY PERSON(S) AUTHORIZED TO RECEIVE ACADEMIC INFORMATION:
In accordance with the consent of the above student, I accept full responsibility for any and all information contained in the academic record that may be released to me, and agree to abide by the following procedures and provisions:

- All requests for information will be submitted by me in writing or on a form supplied by the University. I understand that academic information may not be discussed over the telephone._____**Initial**
- The University may charge its normal fee (if any) for the services requested and provided. _____**Initial**
- The student may rescind the authorization at anytime. I understand the University is not responsible for the non-release of future academic information should the student rescind this authorization. _____**Initial**

Signature:_____Date Signed:_____

For information about the Family Education Rights and Privacy Act of 1974, as amended, direct inquires to:	**FOR REGISTRAR OFFICE USE ONLY DO NOT WRITE IN THIS SPACE**
UAMS Registrar Office Admin West Room 304 Little Rock, Arkansas 72205 Telephone: (501) 686-5730 FAX: (501) 686-6855 *Return completed forms to this address*	_____ **Recorded By** _____ **Date:**

_____COPY TO: Person Authorized to receive Academic Information. This is to acknowledge receipt of authorization for you to receive academic record information at the University of Arkansas for Medical Sciences for the student listed on this form. Observe the procedures outlined in the agreement section when you request information.