

AUTHORIZATION OF DISCLOSURE CONSENT FORM

I, _____
(Name of Student)

authorize _____
(Individual/Department/University)

to disclose to: _____

(Name, title, and address of person(s) to which disclosure is to be made)

the following identifying information from my records (specify extent or nature of information to be disclosed):

The purpose or need for such disclosure is: _____

This consent (unless expressly revoked earlier) expires upon:

(Specify date, event, or condition upon which it will expire)

Signature of student: _____	Date: _____
Signature of witness: _____	Date: _____