UNIVERSITY OF ST. AUGUSTINE
FOR HEALTH SCIENCES

Authorization to Release information

FERPA Release Form

____ __________________
Student Name (Please Print) Student I.D. Number

In accordance with the Family Education Rights and Privacy Act of 1974 (FERPA), the undersigned student herby permits the University of St Augustine for Health Sciences to disclose the information specified below to the following individuals(s) or agency (ies). The student authorizing the release of his/her educational records must sign and present this form to the appropriate office with a photo ID to verify authenticity of this release.

Name: ____

Name: ____

Name: ____

Check below to indicate which records you wish to make available:

________ **All Financial Aid/ Assistance Records** (records include: status of file, award and disbursement of funds information, Satisfactory Academic Progress status, income information, and any other information contained in the application or financial aid file).

________ **All Student Account Records** (records include: amount for tuition and fees, sources of payment for tuition and fees, refund information, records hold information as it relates to parking tickets, library fines, financial aid repayments and any other account receivables information contained in the student account).

________ **Others** (Please Specify) ____

I understand the information may be released orally or in the form of copies of written records, as preferred by the requester. This authorization will remain in effect from the date it is executed until revoked by me, in writing, and delivered to the Department(s) identified above.

____ __________________
Student Signature Date