



Consent for Release of Student Information

Student Name _____ Student ID _____

Student SSN _____ Date of Birth _____

I, _____, authorize Gateway Technical College to release the (student name) information indicated below to the following persons (Please indicate full name and relationship to you):

Full Name	Relationship
_____	_____
_____	_____
_____	_____

This request should only include records between the dates of _____ and _____.

This request expires:

- Upon release to the specified individuals
- On _____ (date)

Information to be released	Initials (initial all that apply)
Academic Records (grades, courses enrolled in including Adult High School, GED/HSED)	
Disciplinary Actions	
Financial Aid Records (Awards, tax information)	
Medical Records (as they pertain to the academic record)	
Other (Specify)	

I understand that my records are protected under the Federal Family Educational Right to Privacy Act and cannot be disclosed without my written consent unless otherwise provided for in this act. The information will not be further disclosed to another person or institution or used for any purpose other than that stated in this authorization. I also understand that I may, in writing, revoke this consent at any time except to the extent that action has been taken in complying with the original request.

I further understand that the information to be released was explained to me and this consent is given of my own free will.

Student Signature

Date

Signature of Parent of Guardian if Student is under 18 Yrs. of age

Date