The University of Akron

Authorization and Request

For

Release of Records and Information

College of Health Professions

Office of Student Affairs

Akron, OH 44325-3701

Voice: 330-972-5103 Fax: 330-972-5493

To: Record Custodians

The University of Akron

Akron, OH 44325

You are hereby authorized and instructed to disclose, make available, furnish and release the following information relating to or concerning me to the assignee(s) without my further consent:

Authorized Individual(s) Name(s): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship to Student: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_ Academic Grades/Records \_\_\_\_\_ Enrollment \_\_\_\_\_ Other Information

\_\_\_\_\_ Health Record Information \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

This authorization shall be considered as a waiver of any and all rights and/or privileges as provided under the Family Educational Rights and Privacy Act of 1974 (FERPA) and/or the Gramm-Leach-Bliley Act (GLBA).

A photocopy of the authorization shall be considered as valid as the original document.

Note to Student: To finalize the processing of your Authorization Request, YOU must deliver this form IN PERSON to the appropriate office along with photo identification. This form will not be accepted without proof of identification in order to ensure the protection of your information.

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name (please print)

Student ID Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature