

**AUTHORIZATION TO RELEASE INFORMATION
FROM ACADEMIC RECORDS**

(* REQUIRED) PLEASE PRINT ALL INFORMATION. Incomplete forms cannot be processed.

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 Central Arkansas 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.

*SIGNATURE: _____

*PRINTED NAME: _____

*STUDENT I.D. NUMBER: _____

*DATE SIGNED: _____

**IDENTITY OF PERSON(S) AUTHORIZED TO RECEIVE ACADEMIC INFORMATION
PLEASE PRINT**

*NAME: _____

*ADDRESS: _____

*CITY: _____

*STATE: _____ ZIP: _____

*RELATION TO STUDENT: _____

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:

1. 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.
2. The University may charge its normal fee (if any) for the services requested and provided.
3. 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.

SIGNATURE: _____

PRINTED NAME: _____

DATE SIGNED: _____

For information about the Family Education Rights and Privacy Act of 1974, as amended, direct inquires to:

Return completed form to:

University Registrar
University of Central Arkansas
McCastlain Hall, Room 112
Conway, Arkansas 72035-0001
Telephone: (501) 450-5200
FAX: (501) 450-5734

FOR OFFICE OF THE REGISTRAR USE ONLY - DO NOT WRITE IN THIS SPACE

Effective Term: Fall Spring Summer **Year:** _____

Recorded by: _____ **Date:** _____

COPY TO: Person(s) Authorized to receive Academic Information.

This is to acknowledge receipt of authorization for you to receive academic record information at the University of Central Arkansas for the student listed on this form. Observe the procedures outlined in the agreement section when you request information.