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# FERPA STUDENT INFORMATION RELEASE FORM

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DATE    \_\_\_ / \_\_\_ / \_\_\_

I \_\_\_\_\_ understand that under the provision of the Family Educational Rights and Privacy Act (FERPA) of 1974, as amended, my education records, including records relating to medical care I may receive, at John Cabot University will not be released to a third party without my written consent.

I hereby **(1)**  **give permission** **(2)**  **revoke permission** to authorized personnel at John Cabot University to release my records [i.e. *academic records, medical records, financial assistance, conduct and housing issues*], upon request, only to the following individual(s):

BENEFICIARY FULL NAME	
RELATIONSHIP	
FULL ADDRESS	
BENEFICIARY'S EMAIL	

BENEFICIARY FULL NAME	
RELATIONSHIP	
FULL ADDRESS	
BENEFICIARY'S EMAIL	

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I acknowledge by my signature that I understand that, although I am not required to release my records to these individuals, I am granting permission to university personnel to release my personal records. I understand that this release will remain in effect until I revoke my permission in writing. I also understand that if I am under 18 years old, John Cabot University can disclose such information to *parents* and *legal guardians* regardless of consent. **Please honor requests for my records by those individuals/parties identified above.**

STUDENT SIGNATURE		___ / ___ / ___
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