



FERPA RELEASE OF INFORMATION FORM

Student ID # _____

I _____ hereby request and authorize **Atlanta Metropolitan State College** and (First, Middle, Last Name)

their designated staff to share information with _____
(Parent/Guardian's Name)

Address of Releasee (Parent/Guardian):

1. Description of Information to be released:

2. Reason for release of information:

3. Release Information for period of: (Check One)

☐ One Semester (Valid from _____ to _____)

☐ One Time Use

Other Restrictions and Conditions:

This Consent to Release Records is limited to those persons expressly named herein. Any further release of records/information to any other person, group, corporation or entity of any kind or nature is expressly prohibited without the further written consent of the student. The records listed above will be released in unedited form except as otherwise provided by the Family Educational Rights and Privacy Act of 1974 and regulations promulgated there under applicable state law, and the policies and procedures of the University. **THE STUDENT HAS THE RIGHT TO DENY ACCESS TO THE INFORMATION LISTED ABOVE AND/OR TO REVOKE THIS CONSENT AT ANY TIME.** In signing this consent form, the student and/or the student's legal guardian agrees to permit the release of information.

I authorize the above-mentioned entities to share information by phone, in person, and/or email contact. I understand that all information will be held strictly confidential and cannot be released by the recipient without my written consent. I understand that this authorization will remain in effect for the time period designated and that my consent may be withdrawn at any time.

Signature of Student

Date

Signature of Parent or Guardian

Date

Signature of Counselor

Date

USE THIS SPACE ONLY IF STUDENT/CLIENT WITHDRAWS CONSENT

Signature of Student/Client

Date