COCHISE COLLEGE

AUTHORIZATION FOR RELEASE OF INFORMATION

Expiration Date ______________
Copy for Student ______________
SGASTDN Notes ____________
Op/Date ____________________

DATE:	NAME OF STUDENT (Last, First, Middle Initial):	STUDENT ID NUMBER:

☐ **Consent for FULL ACCESS to Educational Records:** (Full access does not give authority to make changes to the student's educational record.)

☐ **Consent for LIMITED ACCESS to Educational Records:** (Limited access does not give authority to make changes to the student's educational record.)

☐ Only my Cochise College transcript.

☐The following specific information or records:

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☐ One Time Use: This authorization can be used only once.

☐ Limited Use: This authorization expires on ____

☐ Long Term Use: This authorization will remain continuously in effect until I withdraw this authorization in writing or for a **maximum of one year**.

PURPOSE FOR THE AUTHORIZATION FOR RELEASE OF INFORMATION:

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Name of Individual or Agency to whom access to records may be provided:

____

Address of Individual or Agency: ____

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I understand that some of my records may be protected under the Family Educational Rights and Privacy Act of 1974 and cannot be released without my written consent. I hereby waive all provisions of the law and privilege relating to the records described in this disclosure. I certify that this consent has been given freely and voluntarily. I may revoke this consent at any time by providing written notice of such revocation to the Cochise College office or person who maintains the records of this authorization. This authorization is good for one year from the date I sign this release, unless noted differently above, and photocopies of this release form may be accepted, when presented in person with appropriate identification.

______________________________ ______________________________
Student Signature Date