



**VCU**

**FERPA CONSENT TO RELEASE STUDENT INFORMATION**

Case No: \_\_\_\_\_

The Family Educational Rights and Privacy Act of 1974 (FERPA) requires a student to authorize in writing the release of the student’s educational records. Please complete and sign this form to authorize release of your educational records to the individual designated below.

Please provide information from the education records of:

Student’s name: \_\_\_\_\_

To: Name(s) of requestor: \_\_\_\_\_

Relationship to the student such as “parent,” “spouse,” “prospective employer,” or “attorney”:

\_\_\_\_\_

Password/code (select an identifier to provide requestor): \_\_\_\_\_

Records that may be disclosed: (Initial next to each option that applies)

\_\_\_\_\_ Release all files and records pertaining to me

\_\_\_\_\_ Release information pertaining to case number: \_\_\_\_\_

\_\_\_\_\_ Release information pertaining to the meeting/investigation/hearing on \_\_\_\_\_ (date)

\_\_\_\_\_ **REVOKE** all current authorization(s) for release of my records

**Note: This consent does not cover medical records held solely by Student Health Services or University Counseling Services. Contact those offices for consent forms.**

Student Declaration: I understand the information may be released orally or in the form of copies of written records, as preferred by the requestor. I understand that this form remains in effect until otherwise revoked by me.

Student Name (print): \_\_\_\_\_

Student Signature: \_\_\_\_\_

Student ID Number: **V**\_\_\_\_\_ Academic Year: \_\_\_\_\_ Date Signed: \_\_\_\_\_

**Submit this form via your VCU email to [TitleIX@vcu.edu](mailto:TitleIX@vcu.edu)**

**Equity and Access Services**

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