

STUDENT CONSENT TO RELEASE EDUCATION RECORDS



Please type or print in ink all information requested.

In accordance with Valencia College policies and procedures, as well as state and federal law (FS 228.093, 20 U.S.C.A. 1232g),

I, _____, freely and voluntarily consent to the release of information from my education record to the following:

NAME OF PARTY TO WHOM DISCLOSURES MAY BE MADE			NAME OF PARTY TO WHOM DISCLOSURES MAY BE MADE		
ADDRESS OF PARTY			ADDRESS OF PARTY		
CITY	STATE	ZIP	CITY	STATE	ZIP
PHONE			PHONE		
NAME OF PARTY TO WHOM DISCLOSURES MAY BE MADE			NAME OF PARTY TO WHOM DISCLOSURES MAY BE MADE		
ADDRESS OF PARTY			ADDRESS OF PARTY		
CITY	STATE	ZIP	CITY	STATE	ZIP
PHONE			PHONE		

Is the party or parties a parent or legal guardian? Yes No Who? _____

Purpose of Disclosure: _____

Education Record(s) Which May Be Disclosed:

All Education Records Other (please specify) _____

Period of Time During Which Consent Shall Be Valid From: _____ To: _____

If no date is indicated, the consent will expire when the student ceases to be a student at Valencia College.

STUDENT'S VALENCIA ID / SSN	STUDENT'S MAILING ADDRESS				
CITY	STATE	ZIP	STUDENT'S PHONE		

STUDENT SIGNATURE (REQUIRED) _____

DATE _____