UNIVERSITY OF ARKANSAS

Student Consent to the Release of Education Records

Student ID: _____ Name: _____

Choose One

○ I hereby consent to the release of ANY OR ALL of my University of Arkansas, Fayetteville, education records.

OR

○ I hereby consent to the release of THESE SPECIFIC education records.
I understand that until I withdraw this consent in writing or until such time as I have not been enrolled for two full calendar years, this consent will remain active. (Please enter below the records releasable below.)

_____

I grant authorization to release my records, as indicated above to the following parents, guardian or family members.

Name: _____ Name: _____

Address: _____ Address: _____

City: _____ State: _____ Zip Code: _____ City: _____ State: _____ Zip Code: _____

Phone Number: _____ Phone Number: _____

[Note: under Federal law, education records **may** be disclosed to parents of dependent students (as defined under the Internal Revenue Code) without consent of the student. 34 CFR § 99.31(a)(8).]

I grant authorization to release the above indicated records to other person(s), agency(ies), institution(s), organization(s) or classes of persons listed here.

Name: _____ Name: _____

Address: _____ Address: _____

City: _____ State: _____ Zip Code: _____ City: _____ State: _____ Zip Code: _____

Phone Number: _____ Phone Number: _____

This authorization

Signature: _____ Date: _____

Return form to:
Office of the Registrar
141 Uptown East Fayetteville AR 72701
Phone (479) 575-5451 Fax (479) 575-4651
Or submit by email to registra@uark.edu