Student Consent to Release Information

In compliance with the Family Educational Rights and Privacy Act (FERPA) of 1974 as Amended, Cabarrus College of Health Sciences will not release student information beyond the college's directory information (with exceptions as outlined in § 99.31) to any third party without written permission by the student.

Completed form should be returned to:
Director of Student Records & Information Management
Cabarrus College of Health Sciences
401 Medical Park Drive
Concord, NC 28025
704-403-3218 (phone) 704-403-2077 (fax)

Student Information

Student Name: _____ Social Security Number: _____

Name while attending school (if different): _____ Date of Birth: _____

Dates of Attendance: _____ to _____ Phone #: _____

Current Address: _____

Email Address: _____

Component of Record Requested (indicate quantity):

_____ *Transcript** _____ *Medical Record** _____ *Reference* _____*Other (specify)* _____

**fees apply for transcript & medical record release*

Transcripts or other records will not be released to students with outstanding financial obligations or loan defaults with the College.

Authorized Offices or Personnel

I authorize the offices or personnel at Cabarrus College of Health Sciences (identified below) to release information regarding my educational record which may contain personal identifiable information and can include (but is not limited to) admission, academic performance, advisement, grades, student employment and disciplinary files.

Name, Title & Department: _____

Name, Title & Department: _____

Name, Title & Department: _____

Name, Title & Department: _____

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Release To:

I authorize the following individual(s) (parent(s), guardian, spouse, employers, clinical sites, etc.) access to the above component of my educational record:

Name _____ *DOB** _____ *Relationship*_____

*Address & Phone*_____

Name _____ *DOB** _____ *Relationship*_____

*Address & Phone*_____

Name _____ *DOB** _____ *Relationship*_____

*Address & Phone*_____

Name _____ *DOB** _____ *Relationship*_____

*Address & Phone*_____

**this information will be used for identification purposes only*

Statement of Understanding

I understand this release expires upon written revocation. I understand I have the right to a) request a review of my educational records at any time, b) request an amendment of my records should I believe there is a discrepancy, c) refuse the release of my education records and d) revoke this release at any time and must do so in writing and give my written revocation to the office of Student Records & Information Management.

Student's Signature _____ **Date**_____

FOR ADMINISTRATIVE USE ONLY

Request Completed by_____on_____

Amount Paid_____ Date_____ Ck#_____ Cash_____ CC_____ Processed by_____