



The Office of the Registrar
60 Cleveland Ave.
Columbus, Ohio 43215
Phone (614) 222-3295 Fax (614) 222-4034

CONSENT TO RELEASE INFORMATION FROM STUDENT RECORDS

STUDENT'S NAME _____
LAST FIRST MIDDLE

STUDENT'S ID NUMBER ____ / ____ / ____

The Following individual/organization desires that certain information be released from your education records.

Name/Organization : _____
 Address : _____
 City/State/Zip: _____
 Telephone: (____) _____
 Fax: (____) _____
 Other pertinent Information (i.e. policy numbers, parent/guardian names):

Please send the following information:

(Check all that apply)

- ____ Student Grade Copy (Unofficial Transcript)
- ____ Degree/Enrollment Verification
- ____ Copy of Content Schedule

The above named individual requires this information for the following reason: (Check one)

- ____ Insurance Deferment
- ____ Loan Deferment
- ____ Other: _____

Unless you do not specify that you do not want your Social Security Number released we will assume your signature is your written consent to release this number.

I hereby give my consent to the release of information specified above for the purpose indicated and acknowledge that a duplicate copy of this form has been given to me.

Student Signature Date

OFFICE USE ONLY

DATE RECEIVED _____ RECEIVED BY _____
DATE PROCESSED _____ PROCESSED BY _____