

CONSENT TO RELEASE STUDENT EDUCATIONAL RECORDS

I, _____, _____ of
(Student's Name) (ID Number)
_____, hereby consent and grant to the
(Permanent Address)
University of Rhode Island, Kingston RI 02881, full authority and permission to
duplicate and release the following records to _____
(Person or entity to which records will be given)
_____, according to the following terms:
(Address of person or entity to which records will be given)

University of Rhode Island
Enrollment Services Green Hall
6 Rhody Ram Way
Kingston, RI 02881 USA

Fax Completed Form To:
401-874-2910

Phone: (401) 874-9500
Website: www.uri.edu/enrollment

1. Description of records to be released:

2. Reasons for release of records:

Other Restrictions and Conditions:

This Consent to Release Records is limited to those persons expressly named herein. Any further release of records to any other person, group, corporation, or other entity of any kind or nature is expressly prohibited without further written consent of the student.

The records listed above will be released in unedited form except as otherwise provided by the Family Educational Rights and Privacy Act of 1974 and Regulations promulgated thereunder, applicable state law, and the policies and procedures of the University. The student has the right to deny access to the records listed above and/or to revoke this consent at any time. In signing this consent form, the student and/or the student's legal guardian agrees to permit the release of these records.

Having read and understood this consent form, the student and/or legal guardian has signed below as their free act and deed.

(Witness) (Signature of Student)

If the student is under age 18 as of the date of this release, a legal guardian must also sign this consent form.

(Witness) (Signature of Guardian)

(Printed Name of Legal Guardian)

Dated: _____

Subscribed and sworn to before me this _____ day of _____, 2____

My commission expires: _____
(Notary Public)

