STUDENT CONSENT FOR RELEASE OF ACADEMIC RECORDS

To: Associate Dean
Admissions, Registration & Records
Central Texas College
P.O. Box 1800
Killeen,TX 76540
Fax: (254) 526-1545

From:_____
Name of Student Student ID

_____
Street Address City State Zip Code

_____
Home Phone Number Alternate Phone Number email

Under Federal legislation, namely the Family Educational Rights and Privacy Act of 1974, I understand that my educational records cannot be released without my written permission or a Parental Affidavit of Dependency certified by my parent or guardian.

I, therefore, request that the information listed below be released to the following:

_____
Name

_____
Street Address City State Zip Code

Valid: (*circle **one** only*) Spring Summer Fall _____
Year

Information to be released:

☐ Registration ☐ Grades ☐ Transcripts ☐ Business Office ☐ VA ☐ Financial Aid

☐ Other _____

Purpose of request:

_____

_____

Signed this_____day of _____

_____
Student's signature