STUDENT CONSENT FOR RELEASE OF ACADEMIC RECORDS

To: Systems Registrar
Central Texas College
P.O. Box 1800
Killeen, TX 76540
Fax: (254) 526-1111

From: ____

Name of Student Social Security Number

____

Street Address City State Zip Code

____

Home Phone Number Alternate Phone Number

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

Information to be released:

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Purpose of request: ____

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Signed this _____________ day of ______________________________

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Student's signature