

## STUDENT CONSENT FOR RELEASE OF ACADEMIC RECORDS

To: Systems Registrar  
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: Spring \_\_\_\_\_ Summer \_\_\_\_\_ Fall \_\_\_\_\_  
Year Year Year

Information to be released:

Registration  Grades  Transcripts  Business Office  VA  Financial Aid

Other \_\_\_\_\_

Purpose of request:

\_\_\_\_\_  
\_\_\_\_\_

Signed this \_\_\_\_\_ day of \_\_\_\_\_

\_\_\_\_\_  
Student's signature