THE UNIVERSITY OF ARIZONA
College of Medicine
Tucson

Return Form to:
Student Records Office
1501 North Campbell Avenue
PO Box 245026, 85724-5026
Fax: 520/626-6300

Authorization for Release of Student Records

Date:

Student Name: Prior Name:

Contact Phone: Last 4 of SSN:

Contact Email:

I consent to send the following Items:

- ☐ Dean's Letter
- ☐ Letter of Degree Verification
- ☐ Transcript
- ☐ Diploma Certification
- ☐ Other:_____

Purpose for the Authorization:

Name of Individual or Agency to whom records may be provided:

Address of Individual or Agency:

I understand that some of my records may be protected under the Family Educational Rights and Privacy Act of 1974 and cannot be released without my written consent. I hereby waive all provisions of the law and privilege relating to the records described in this disclosure. I certify that this consent has been given freely and voluntarily. I may revoke this consent at any time by providing written notice of such revocation to the University office or person who maintains the records of this authorization. This authorization is good for one year from the date I sign this release, unless noted differently above, and photocopies of this release form may be accepted, when presented in person with appropriate identification. The person and or agency receiving this information may not disclose the information received as a result of this disclosure unless specifically authorized in the "purpose" section of this release.

_____ _____

Student Signature Date