Permission to Release Education Record Information

I give permission for the Texas A&M Health Science Center to release my

____
(education record information to be released)

to the below named parties for (purpose)

____

____

All permission granted will stay in effect until revoked, in writing, by me. I understand I may revoke this consent at any time. I understand that any revocation of this consent must be in writing.

PLEASE PRINT CLEARLY

Release to____
Name Relationship Phone Number

Release to____
Name Relationship Phone Number

Release to____
Name Relationship Phone Number

Release to____
Name Relationship Phone Number

____
Student Printed Name Student Signature Date

*Please use the back of this form to document multiple communications.

With few exceptions, state law gives you the right to request, receive, review and correct information about yourself collected on this form.