



Authorization to Release Student Education Record Information

Office of the Registrar

Burrell College of Health Sciences complies with the Family Educational Rights and Privacy Act, 20 U.S.C. § 1232g ("FERPA") and FERPA's implementing regulations, 34 C.F.R. § 99.1, et seq. Subject to certain exceptions, the College does not disclose a student's educational records and information to others without the student's written authorization. Students may sign this Authorization to Release Student Education Record Information form to authorize the College to disclose the students' records and information subject to the law, applicable policies, and the parameters and restrictions set forth below. Information about the College's FERPA compliance is available at: <https://burrell.edu/students/resources/office-of-the-registrar/>.

I. Student Information:

Name of the Student: _____

Address: _____
Box or Street # City State Zip Phone

Student ID Number: _____ Burrell Email: _____@burrell.edu

II. Recipient Information:

I authorize the College to release my educational records to the person(s) specified below:

Name(s): _____

Address: _____
Box or Street # City State Zip Phone

For the purpose of informing **(check below)**:

- ☐ Family
- ☐ Educational Institution
- ☐ Honor or Award
- ☐ Employer/Prospective Employer
- ☐ Public or Media of Scholarship
- ☐ Other (Please Specify) _____

III. Consent:

Pursuant to the provisions of the Family Educational Rights and Privacy Act of 1974, as amended (FERPA), I give my consent to authorized representatives of Burrell College of Osteopathic Medicine for the release of information regarding my account as indicated below:

Student Information Type (check below)	Description (Including, but not limited to, the following):
☐ Business Account	Account balance, charges, credits, past due balances, third party sponsorship
☐ Financial Aid	Award information, scholarship(s)
☐ Academic Records	Student enrollment, academic records, grades, schedule, Veteran's benefits

IV. Duration of Release (check one):

- ☐ One-Time Use: This authorization is only applicable as of the date indicated following the signature below.
- ☐ Limited Use: This authorization shall expire at the end of a year or term as indicated here: _____
- ☐ Unlimited Access: This authorization is valid until a written revocation is obtained from the granting student.

I understand that I have the right to rescind this authorization at any time.

Student Signature: _____ **Date:** _____

Burrell College of Health Sciences
Office of the Registrar
3501 Arrowhead Drive, Las Cruces, NM 88001

Notary:

If not delivering in person, the section below must be completed by a Notary Public. The College reserves the right to contact the student to authenticate the student's signature before disclosing records or information.

State of _____ County of _____

On this _____ day of _____, 20____, _____ personally appeared before me,

(Check One): ☐ who is personally known to me OR ☐ whose identity I proved on the basis of _____, to be the signer of the above instrument.

Notary Public _____

Residing at _____

My commission expires: _____

OFFICE USE ONLY:

Processed by: _____ Date: _____