CONSENT TO THE RELEASE OF INFORMATION

STUDENT NAME: _____

STUDENT IDENTIFICATION NUMBER: _____

EDUCATIONAL RECORD(S) TO BE RELEASED: Student Conduct Record

NAME AND ADDRESS, EMAIL, OR FAX NUMBER OF THE PARTY TO WHOM DISCLOSURE OF RECORDS MAY BE MADE, "AUTHORIZED RECIPIENT(S)":

_____

_____

_____

PURPOSE OF DISCLOSURE:

☐ Transferring to other Institution

☐ Graduate College

☐ Medical School / Law School

☐ Student Code of Conduct Procedures

☐ Other: _____

By presenting a signed and dated copy of this Consent to Arizona State University "ASU," Student consents to the release by ASU of the Records to the Authorized Recipient(s) for the Purpose identified above. The Student further agrees that ASU may discuss the information contained in the Records with the Authorized Recipient(s). This Consent applies to educational records that may otherwise be protected under the Family Educational Rights and Privacy Act of 1974, as amended, 20 U.S.C. 1232g.

NAME (please print): _____

SIGNATURE: _____

DATE: _____

PHONE AND EMAIL: _____

For Office Use Only

Request fulfilled by:

_____	_____	_____
STAFF (Please Print)	Signature	Date