



Academic Records/Registrar's Office

**** Students Consent to the Release of Education Records****

Name: _____ UAPB ID/SSN: _____

Choose One:

I hereby consent to the release of **ANY OR ALL** of my University of Arkansas at Pine Bluff, education records.

OR

I hereby consent to the release of **THESE SPECIFIC** education records.

I understand that until I withdraw this consent in writing or until such time as I have not been enrolled for two full calendar years, this consent will remain active. (Please enter below the records releasable below.)

I grant authorization to release my records, as indicated above to the following parents, guardian, or family members listed here:

Name: _____ Address: _____

City: _____ State: _____ Zip Code: _____

Phone Number: _____

[Note: under Federal law, education records may be disclosed to parents of dependent students (as defined under the Internal Revenue Code) without consent of the student. 34 CFR § 99.31(a)(8).]

I grant authorization to release the above indicated records to other person(s), agency(ies), institution(s), organization(s) or classes of persons listed here:

Name: _____ Address: _____

City: _____ State: _____ Zip Code: _____

Phone Number: _____

Signature: _____ Date: _____

Return form to:

Academic Records | Mail Slot 4983 - 1200 North University Drive | Pine Bluff, AR 71603
Phone (870) 575-8487 Fax (870) 575-4608 (Please call the general number for instructions on e-mailing this form.)