

POST CAMPUS • LONG ISLAND UNIVERSITY 720 NORTHERN BLVD., BROOKVILLE, NY 11548 • 516-299-2765

Instructions:

Option 1: Take this form and sign it in person at the Enrollment Services Office.

Option 2: Return the completed, signed and notarized authorization to the Enrollment Services Office (Post or Brooklyn); or to the Dean's Office at Brentwood, Riverhead or the Westchester and Rockland Graduate Campus.

AUTHORIZATION TO DISCLOSE ACADEMIC INFORMATION TO THIRD PARTIES

In accordance with the Family Educational Rights & Privacy Act (FERPA), The University will disclose information from the education record of a student provided the University has on file written consent of the student. If you consent to the release of your education record, please sign below and return to Enrollment Services. This authorization remains in force until a letter requesting the cancellation of the authorization is received by Enrollment Services.

Student Name:			ID:	
		(please print)		
	nt. For example	e, "parent", "guardian", "prospect	vidual(s). Please list the name(s), and the tive employer", "attorney" or list "other" and	
(c)			nship to Student	
(Note: this consent does not co	ver medical record	ds held solely by University Health/Medical	Services – contact that office for consent forms.)	
STUDENT'S SIGNATURE	Ē:		DATE:	
To be completed by the	Office of Enr	rollment Services		
Received by:				
Signature Witnessed by:				
Photo ID Presented:				
Entered into PeopleSoft:				
	Date	Signature of staff member	er	