New Paltz
STATE UNIVERSITY OF NEW YORK

AUTHORIZATION TO RELEASE INFORMATION

The Family Educational Rights and Privacy Act (FERPA) protects student confidentiality by placing certain restrictions on the disclosure of information contained in a student's education records. By signing this form, you agree that university personnel may provide information from your education records as indicated below.

Name of Student _____ DOB _____/_____/_____
MM DD YY

I, the undersigned, authorize SUNY New Paltz to release the following educational records and/or any information contained therein. (please identify specific records, types of records, or indicate "all records"):

_____

_____

_____

To (person/agency to receive information):

_____
Last Name First MI

_____
Agency

_____
Street

_____
City State Zip Code

For the purpose of:

_____

_____

_____

I understand and acknowledge that (1) I have the right not to consent to the release of my education records; and (2) this consent shall remain in effect until revoked by me, in writing, and delivered to SUNY New Paltz, but that any such revocation shall not affect disclosures made prior to the receipt of any such written revocation.

I understand that the records to be disclosed may include my social security number and other personally identifiable information. This information may not be redisclosed to others and will be destroyed as soon as all statistical analysis has been performed, or when the information is no longer needed, whichever date comes first.

_____ _____
Student's Signature Date

PLEASE RETURN COMPLETED FORM TO: _____
(Campus official who requested this release)

OR TO: Office of Records & Registration
State University of New York at New Paltz
1 Hawk Drive
New Paltz, NY 12561-2443