TheChicagoSchool of Professional Psychology

Office of the Registrar

FERPA – STUDENT AUTHORIZATION RELEASE FORM

SUBMIT COMPLETED FORM TO:

CHICAGO/GRAYSLAKE/ NEW ORLEANS AT XULA	ONLINE	SOUTHERN CALIFORNIA	WASHINGTON, D.C.
800.684.2890 (phone) 312.488.6301 (fax) CHIRegistrar@thechicagoschool.edu	800.684.2890 (phone) 312.254.1442 (fax) OnlineRegistrar@thechicagoschool.edu	800.684.2890 (phone) 213.615.7286 (fax) CARegistrar@thechicagoschool.edu	800.684.2890 (phone) 202.706.5199 (fax) DCRegistar@thechicagoschool.edu

STUDENT NAME: ______________________________ **STUDENT ID #:** ______________________

TCSPP E-MAIL: ______________________ **PHONE #:** _____ **LOCATION:**

TERM AND YEAR: ______________________ **DEGREE LEVEL:** **PROGRAM:** ______________________

STUDENT SIGNATURE: ______________________________ **DATE**: ______________________

In accordance with regulations contained within the Family Educational Rights and Privacy Act (FERPA), The Chicago School of Professional Psychology will disclose to designated parties information from the educational records of a student, provided the School has on file written consent by the student.

I, ____, freely and voluntarily consent to the release of information from my educational records. In giving permission to **The Chicago School of Professional Psychology** to make such disclosure(s), I also state as follows:

1. **Name of Party to Whom Disclosure May Be Made (please print):**

   ____

   Party

2. **Address of Party or Parties to Whom Disclosure May Be Made (please print):**

   Address: ____

   City: ______________________________ State: ______________________

   Phone ______________________________

3. **Purpose of Disclosure (please print):**

   ____

   ____

4. **Information from the following offices can be shared:**

☐ Office of the Registrar ☐ Financial Aid ☐ Student Accounts

This release does not permit the disclosure of these records to any other persons or entities without my written consent unless specifically allowed for within FERPA regulations. I understand it is my responsibility to revoke this authorization at any time.

STUDENT SIGNATURE: ______________________________ **DATE**: ______________________
(handwritten)

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For Office Use Only

Office of the Registrar: ______________________________ Date: __________ CVUE: __________

Revised: May 2014