UNK AUTHORIZATION OF DISCLOSURE CONSENT FORM

ID #: ____________________________ Phone #: _________________________________

I, ____________________________

(Name of Student)

authorize ____________________________

(Individual/Department/University)

to disclose to: ____________________________

________________________________

________________________________

(Name, title, and address of person(s) to which disclosure is to be made)

the following identifying information from my records (specify extent or nature of information to be disclosed):

________________________________

________________________________

________________________________

The purpose or need for such disclosure is: ____________________________

________________________________

________________________________

This consent (unless expressly revoked earlier) expires upon:

________________________________

(Specify date, event, or condition upon which it will expire)

Signature of student: ____________________________ Date: __________

Signature of witness: ____________________________ Date: __________