AUTHORIZATION OF DISCLOSURE CONSENT FORM

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: _________________