# 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: _____