

Student Consent To Release Education Records

VALENCIA

Please Print All Information

STUDENT INFORMATION

NAME (PLEASE PRINT)

DATE OF BIRTH (MM/DD/YYYY)

SSN # OR VALENCIA ID

STUDENT'S MAILING ADDRESS

CITY

STATE

ZIP

STUDENT'S PHONE

In accordance with Valencia Community College policies and procedures, as well as state and federal law (2007 Florida Statutes, 1002.22)

I, _____, freely and voluntarily consent to the release
of information from my education record as follows:
STUDENT'S NAME

1.

NAME OF PARTY TO WHOM DISCLOSURES MAY BE MADE

NAME OF PARTY TO WHOM DISCLOSURES MAY BE MADE

ADDRESS OF PARTY

ADDRESS OF PARTY

CITY

STATE

ZIP

PHONE

CITY

STATE

ZIP

PHONE

NAME OF PARTY TO WHOM DISCLOSURES MAY BE MADE

NAME OF PARTY TO WHOM DISCLOSURES MAY BE MADE

ADDRESS OF PARTY

ADDRESS OF PARTY

CITY

STATE

ZIP

PHONE

CITY

STATE

ZIP

PHONE

2. Education Records(s) Which May Be Disclosed:

All Education Records

Other (Please Specify) _____

3. Period of Time During Which Consent Shall Be Valid

From: _____ To: _____

If no date is indicated, the consent will expire when the student ceases to be a student at Valencia Community College. The most recent statement pertaining to release of information will apply.

STUDENT'S SIGNATURE

DATE