CONSENT TO RELEASE EDUCATION RECORDS

Student/Alumnus Information:

First and Last Name (at time of attendance): _____

ID/Social Security Number: _____

Street Address: _____City / State / Zip: _____

Phone: _____ Email Address: _____

Dates of Attendance: From_____ To_____ Degree Earned: _____

I freely and voluntarily authorize the University of Detroit Mercy School of Dentistry to release records and information relating to grades, academic and/or clinical performance, disciplinary proceedings, financial aid, schedules, tuition and fees; for the purpose of educational / employment progress to the person/organization indicated below:

(check all appropriate boxes)

- ☐ Dates of Attendance
- ☐ Date and Degree(s) Earned
- ☐ Cumulative Grade Point Average and Rank
- ☐ Specific Grades: _____
- ☐ Academic and/or Clinical Performance
- ☐ Disciplinary Proceedings
- ☐ Financial Aid
- ☐ Schedules
- ☐ Tuition and Fees
- ☐ Other_____

Send Information to:

Name of Individual: _____

Name of Organization/Department:_____

Street Address: _____City / State / Zip: _____

Phone: _____ Email Address: _____

Student/Alumnus Signature _____ Date: _____

THIS INFORMATION IS RELEASE SUBJECT OT HE CONFIDENTIALITY PROVISIONS OF THE FAMILY EDUCATION RIGHT PRIVACY ACT (FERPA) AND OTHER APPROPRIATE STATE AND FEDERAL LAWS AND REGULATIONS WHICH PROHIBIT DISCLOSURE OF EDUCAITON INFORMATION WITHOUT THE SPECIFIC WRITTEN CONSENT OF THE PERSON TO WHOM IT PERTAINS, OR AS OTHERWISE PERMITTED.

Return this form to:

Diana Squires, Dental School Registrar
2700 Martin Luther King Jr. Blvd., Office 461
Detroit, MI 48208-2576

email: squiredl@udmercy.edu
Phone: 313-494-6616
Fax: 313-494-6627