



**Request for Release of Student Information Form**

Office of Graduate Studies

**STUDENT INFORMATION (A copy of your ID must be attached to this form) Form Must Be Typed:**

Last Name	First Name	Student ID Number
Phone Number	Email Address	

**DISCLOSURE:**

**The student must sign this form to receive a copy of the requested information and return form to the Office of Graduate Studies at Alcorn State University.**

FERPA NOTICE: The Family Educational Rights and Privacy Act of 1974 (FERPA) provides for the confidentiality of student educational records. Alcorn State University may neither disclose certain educational information concerning students nor permit inspection of student educational records without the written permission of the student unless such actions are covered by certain exceptions as stipulated by FERPA.

**INFORMATION REQUESTED:**

**PLEASE CHECK TYPE OF INFORMATION TO BE RELEASED**

<input type="checkbox"/> Academic Probation Letter	<input type="checkbox"/> Clearance Form	<input type="checkbox"/> Program of Study
<input type="checkbox"/> Admission Application	<input type="checkbox"/> Educator License	<input type="checkbox"/> Regular Wage Part-Time Employment Approval Form
<input type="checkbox"/> Admission Letter	<input type="checkbox"/> GRE Scores	<input type="checkbox"/> Remission of Fee
<input type="checkbox"/> Appeal Form	<input type="checkbox"/> I-20	<input type="checkbox"/> Test Scores(Specify)
<input type="checkbox"/> OTHER: (Please Specify)		

This release will remain in effect as follows (please initial one of the following options):

- \_\_\_\_\_ Option 1 – This release is a one-time release only
- \_\_\_\_\_ Option 2 – This release will remain in effect from \_\_\_\_\_ (mo/day/year) to \_\_\_\_\_ (mo/day/year)
- \_\_\_\_\_ Option 3 – This release will remain in effect for one year (12 months) from the date of my signature below, unless I revoke such consent in writing, which I may do at any time.

By signing below, I acknowledge that I understand that I am not required to release my records to anyone. I am freely giving my consent to release the information in the manner described above. I verify that I am the applicant requesting release of information from my graduate student record in the Office of Graduate Studies at Alcorn State University.

_____ Date Requested	_____ Date Needed	_____ Student Signature
Identify of Requestor Verified Via: <input type="checkbox"/> Driver's License <input type="checkbox"/> Student ID <input type="checkbox"/> Other, (Specify) _____		
Verified By: _____ Graduate Studies Staff		_____ Date

Mail form to: Graduate Studies, Walter Washington Administration Bldg., 1000 ASU Drive #689, Lorman, Mississippi 39096 or email to [graduatestudies@alcorn.edu](mailto:graduatestudies@alcorn.edu)