OFFICE OF THE COLLEGE REGISTRAR
11011 SW 104th Street, Room R-301
Miami, FL 33176
Telephone (305) 237-2206
Email Address **registrar@mdc.edu**

AUTHORIZATION FOR RELEASE OF EDUCATIONAL RECORDS

This authorization is solely for release of student records. It is NOT a power of attorney and does not permit any person or organization to act on behalf of a student. It is solely intended to permit the release of student educational records.

IMPORTANT NOTES:

- Students must provide their picture identification along with this form.
- The person or persons requesting the information identified herein must also provide picture identification and, if a person or persons is/are acting as representative(s) for an agency, valid proof of authority to act on agency's behalf.
- A copy of this completed form will be provided to the student for whom educational records are being authorized for release.

DATE:	NAME OF STUDENT (Last, First, Middle Initial):	MDC STUDENT ID NUMBER:

☐ **Consent for FULL ACCESS to Educational Records:** (Full access does not give authority to make changes to the student's educational record). Educational Records may include:

- All grades
- All courses/credits
- All class schedules
- Test scores
- Graduation information
- Disciplinary actions
- Immigration information
- Financial information
- Health information

☐ **Consent for LIMITED ACCESS to Educational Records:** (Limited access does not give authority to make changes to the student's educational record).

☐ Only my academic transcript

☐ The following specific information or records:

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☐ One Time Use: This authorization can be used only once.

☐ Limited Use: This authorization is **effective** date .....

and **expires** on date .....

☐ Long Term Use: This authorization will remain continuously in effect until I withdraw this authorization in writing or for a maximum of one year.

PURPOSE FOR THE AUTHORIZATION FOR RELEASE OF INFORMATION: .....

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Name of Individual or Agency to whom access to records may be provided: .....

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Address of Individual or Agency: .....

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I understand that some of my records may be protected under the Family Educational Rights and Privacy Act of 1974 and cannot be released without my written consent. I also authorize the release of my medical records which may be classified as protected health informatin and covered by stated and federal law, including HIPAA. I hereby waive all provisions of the law and privilege relating to the records described in this disclosure. I certify that this consent has been given freely and voluntarily. I may revoke this consent at any time by providing written notice of such revocation to Miami Dade College, Office of the College Registrar. This authorization is valid for one year from the date I sign this release (unless noted differently above) when presented in person with appropriate identification. The person and/or agency receiving this information may not disclose the information received as a result of this disclosure unless specifically authorized in the "purpose" section of this release.

_____ .....

Student's Signature Date

RESET

SR-LEGAL

PRINT

For staff use only

Processed by: _____

Date Processed: _____