CAMPBELL UNIVERSITY

Office of the Registrar

Post Office Box 367
Buies Creek NC 27506
Phone: 910-893-1265
Fax: 910-893-1260

Authorization of Information Disclosure

I, the undersigned, do hereby authorize Campbell University to release information from my educational records to include my transcript of record and/or mid-term progress reports to my parents(s) or to other individuals or entities as listed below. If parents live at the same address, please list them both on the line.

1. _____
Name
_____
Address
_____
City, State, Zip

2. _____
Name
_____
Address
_____
City, State, Zip

3. _____
Name
_____
Address
_____
City, State, Zip

4. _____
Name
_____
Address
_____
City, State, Zip

If person(s) named above are not your parent(s), what is their relationship to you?

_____

The released information will be used for the purpose of _____

_____

_____

I understand that by signing this authorization, I am waiving my rights of non-disclosure of these records under federal law only as to the persons specifically listed. This release does not permit the disclosure of these records to any other persons or entities without my written consent.

_____
Date

_____
Student's Name (print)

_____
Student ID #

_____
Student's Signature