



UNIVERSITY OF CENTRAL FLORIDA

College of Medicine

## FERPA RELEASE AUTHORIZATION FORM

FERPA, the Family Educational Rights and Privacy Act, protects the privacy of student education records. It gives students the right to review their educational records, the right to request amendment to records they believe to be inaccurate, and the right to limit disclosure from those records. An institution's failure to comply with FERPA could result in the withdrawal of federal funds by the Department of Education. For more information on FERPA, please visit the University of Central Florida's registrar website - <http://med.ucf.edu/administrative-offices/student-affairs/registrar/ferpa/>

FERPA protected information includes, but is not limited to:

- Social Security Number
- Student ID (PID or NID)
- ISO Number
- Residency Status
- Gender
- Religious Preference
- Race/Ethnicity
- Grades/GPA
- Student's Class Schedule
- Test Scores
- Academic Standing
- Academic Transcripts
- Email Address
- Photos

**To authorize the release of FERPA-protected information, the student must complete all items below and submit this form to the College of Medicine's Registrar Office.**

Student's Name (please print.): \_\_\_\_\_

Student ID: \_\_\_\_\_

Records for which you authorize release:

- \_\_\_ Email Address
- \_\_\_ Photograph
- \_\_\_ MSPE (Medical Student Performance Evaluation)
- \_\_\_ Transcript (for ERAS and VSAS use only)
- \_\_\_ Other (please list specific records to be released)

I hereby authorize release of above records to:

- ERAS (Electronic Residency Application Service)
- VSAS (Visiting Student Application Service)
- Medical Operational Data System (MODS)
- Other – Name of Individual or Third Party \_\_\_\_\_  
Relationship to student, if applicable \_\_\_\_\_

As required by the Family Educational Rights and Privacy Act of 1974, as Amended (FERPA) and Florida law, by my signature I hereby authorize the College of Medicine, University of Central Florida, to furnish the University records I have noted upon this form the party I have identified above. This authorization shall remain in force until I submit to the College of Medicine's Registrar office a written and signed notification rescinding my permission to release the records noted or until I graduate and am no longer a student at UCF College of Medicine, whichever should come first.

Student Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Revised 9/2014

College of Medicine Office of Student Affairs  
6850 Lake Nona Blvd. Orlando, FL 32827-7408  
(407) 266-1353 • FAX (407) 266-1389