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: _____

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 noted upon this form to the parties identified below. **This authorization shall remain in force for one year or until I submit to the College of Medicine's Registrar office a written and signed notification rescinding my permission to release the records noted, whichever should come first.**

Records for which you authorize release (please initial):

——Academic Performance Information (e.g. grades, exam scores, status with SEPC, etc.)

——Clinical Rotation Schedules

——Credentialing (for clinical rotations)

——Email Address

——MSPE (Medical Student Performance Evaluation)

——Photograph

——Residency Status

——Transcript (for ERAS and VSAS use only)

——Other: _____

I hereby authorize release of above records to (please initial):

——Name of individual or third party: _____

——Contact Information: _____

——Relationship to student (if applicable): _____

Student Signature: _____

Date: _____

Revised 7/2016

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