



Authorization for Release of Information
Carefully read this authorization to release information about you.

I authorize the following person(s) to obtain the indicated information below, relating to my activities as a student at Park University.

Individual # 1 (print full name)	Relationship to student
Security Question for Individual # 1	Response to Security Question
Individual # 2 (print full name)	Relationship to student
Security Question for Individual # 2	Response to Security Question

This information may include, but is not limited to: (Circle all that apply)

- Academic
- Attendance
- Performance
- Account Info
- Disciplinary
- Residential
- Achievement
- Financial Aid

I understand, for financial or lending institutions, medical institutions, hospitals, health care professionals, and other sources of information, a separate specific release will be needed, and I may be contacted for such a release at a later date.

Copies of this authorization that show my signature are as valid as the original release signed by me. This authorization is valid from the date signed below and will continue in effect until my written termination.

Signature (signed in ink)	Date Signed
Full Name (Type or Print Legibly)	Student ID#
Other Names Used	
Permanent Address (Street, City)	
State Zip Code	Home Telephone Number
Email Address	Cell Phone Number

Return completed form to:
 Park University Registrar
 PMB 27
 8700 NW River Park Dr
 Parkville, MO 64152