Student Services Center
(BSB 1-112).
450 Clarkson Ave,
Brooklyn, NY 11433

DOWNSTATE
HEALTH SCIENCES UNIVERSITY

financialaid@dowstate.edu
registrar@downstate.edu
Phone: (718) 270-2488

STUDENT CONSENT TO DISCLOSE EDUCATION RECORDS
Family Educational Rights and Privacy Act (FERPA) of 1974

Instructions to Former Students or Alumni: ***Carefully read the information below. After completing the form, submit it to the Registrar's Office at the SUNY Downstate Health Sciences University.***

In accordance with the Family Educational Rights and Privacy Act (FERPA) of 1974, the SUNY Downstate Health Sciences University must obtain written consent from a student before releasing the non-directory educational records of that student to a third party. Such written consent must be signed and dated by the student, specify the records to be released, state the purpose of the release, and identify the party or class of parties to whom the release may be made. **Students who ask to have directory information withheld will be unable to consent to release non-directory educational records.**

_____
(Student's Name-Print)

_____ _____
(Student's Email Address) **(Student ID or Social Security Number)**

I hereby give my written (notarized) consent to the SUNY Downstate Health Sciences University, State University of New York, to disclose the following information upon request:

- ☐ **Financial Aid Record**
- ☐ **Billing Record**
- ☐ **ID Card Transaction/Account Information**
- ☐ **Disciplinary Record**
- ☐ **Academic Standing**
- ☐ **Violations of Academic Integrity Record**
- ☐ **Residential Life File**
- ☐ **Program Completion Status**
- ☐ **Grades (includes semester GPA and cumulative GPA)**
- ☐ **Class enrollment (no professor(s) or classroom(s) provided)**
- ☐ **Degree Audit**
- ☐ **Student Holds**
- ☐ **Other (Description:_____)**

for the purpose of_____ (Specify purpose of the release)

to _____.

(Identify the party or class of parties to whom the release may be made)

I understand that my written consent will remain in effect until I notify the SUNY Downstate Health Sciences University faculty/staff/office named in this form, in writing (and notarized), to cancel it.

I understand that the specific information referenced in this form is being released to a third party at my request with the understanding that s/he will not release it to any other parties. The SUNY Downstate Health Sciences University is hereby released from all legal responsibility or liability pertaining to the release of the above-mentioned information.

Please note: The SUNY Downstate Health Sciences University must authenticate the identity of a third party before releasing any information from the student's education record. As such, information is never released over the phone, by email, or by fax. In order to release information to a third party, the SUNY Downstate Health Sciences University will authenticate the third party's identity via photo ID either in person or via a Zoom call.

Student's Signature: _____ Date: _____

STATE OF NEW YORK)
COUNTY OF_____) SS.:

On the ____ day of _____, 20___, before me personally came _____, to me known and known to me to be the person described in and who executed the foregoing instrument and he/she acknowledged to me that he/she executed the same.

_____ **Notary Public**

Students are advised to keep a copy of this consent form for their records.