Student Information Release Authorization (FERPA)

Our goals at Mitchell College include supporting students in making a smooth transition from more structured environments, like high school, to independence; developing an understanding of their strengths and interests; and developing seven core abilities, including the ability to seek support and challenge, as needed. To achieve these goals, we generally work directly with students; however, often we find that students benefit from having a network of support that includes family members, outside counselors or health providers with whom we can work collaboratively.

As you probably know, the federal Family Educational Rights and Privacy Act of 1974 (FERPA) and other federal and state laws restrict the College from providing certain information from your student records, such as information on grades, billing, tuition and fees, financial aid, and medical/emotional health records (“Protected Information”) to third parties. In addition, subject to certain exceptions, state law prohibits the College’s counselors from sharing your information with anyone, inside or outside of the College, without your specific written consent.

You may, at your discretion, grant the College and third parties in your “support network,” such as outside counselors and physicians, permission to share Protected Information by submitting this Student Information Release Authorization. This release permits the release and sharing of Protected Information by and with individuals off campus who are in your “support network,” which includes, as applicable, all individuals who are, or who become, involved in supporting you (e.g., parents, outside tutors, therapists, counselors, coaches, physicians, etc.) (the “Network”). In addition, if approved by you below, this release will permit College counselors to share counseling information with other individuals at the College for purposes of providing you appropriate support.

Please note that you make revoke your authorization at any time by sending a written request. It will remain in effect unless revoked.

A. Student Information:

Name: ___________________________ Student ID Number: ___________________________

B. Third-Party Designee(s):

_____ I authorize the release and sharing of Protected Information checked below by and with my Network, as described above, for purposes of supporting my progress and success at Mitchell College.

I wish to exclude the following individuals in my Network from receiving Protected Information. (Please list by name and/or category, as appropriate):

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________
I wish to **include** the following additional parties in my Network for purposes of receiving Protected Information. (Please identify by name and/or category, as appropriate).

*(PLEASE NOTE: PARENTS/GUARDIANS ARE NOT AUTOMATICALLY INCLUDED IN YOUR NETWORK, YOU WOULD NEED TO ADD THEM TO THIS SECTION IF YOU SO CHOOSE.)*

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C. Types of Protected Information I Authorize for Release:

(Only check one or more of the items below to grant authorization)

- [ ] All of the records listed below (i.e., academic records, student account and financial aid records, conduct records, medical records, and emotional health records).
- [ ] Academic records, including, grades/GPA, demographic, registration, academic status, and/or enrollment information.
- [ ] Student Account and Financial Aid records, including billing statements, charges, credits, payments, past due amounts, collection activity, financial aid awards, disbursements, and/or financial aid satisfactory academic progress reports.
- [ ] Conduct Records
- [ ] Medical Record information
- [ ] Emotional Health information (This includes information from College counselors and outside counselors, unless excluded by you above)

D. Counseling Information:

- [ ] I authorize the College counselors to share information with other individuals at the College for purposes of providing me with the appropriate support.

*I understand that I do not have to sign this authorization in order to receive counseling or academic or other support through Mitchell College, but that I may not be able to receive the most comprehensive of support without this authorization.*

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Student Signature ________________________________ Date ________________________________