



# Authorization for Release of Information

Rainy River Community College, 1501 Hwy 71, International Falls, MN 56649  
Office: 218-285-7722 Fax: 218-285-2239

Student Full Name \_\_\_\_\_ Student ID # or Star ID \_\_\_\_\_  
(Please Print)

**I hereby authorize Rainy River Community College to (check all that apply):**

- Release/disclose student record information to
- Obtain information from
- Verbally discuss and exchange information with
- All

\_\_\_\_\_  
(Name of Individual, School, or Organization / Address, City, State, Zip)

**Relationship to Student (circle all that apply):**

Spouse/Partner, Mother, Father, Legal Guardian, Coach, Agency, Other: \_\_\_\_\_

**The following specific records (check all that apply):**

- Academic (such as grades, academic progress, academic planning, attendance, class schedule)
- Registration (such as class schedule, number of enrolled credits, drops/adds, withdrawals)
- Business Office (such as tuition, itemized charges, credits or refunds, payments, balance due)
- Housing (such as application information, damage/sanction charges, and housing policy violations)
- Medical (such as medical history, prognosis, recommendations, or treatment)
- Personal (such as emotional, psychological, social or family history and concerns)
- Legal (such as legal status, history, requirements and recommendations)
- Student Conduct Violations (as listed in the student handbook, and residence life handbook)
- Other: \_\_\_\_\_
- All Records

Note: Financial Aid records (such as grants, scholarships, loan information, awards, disbursements, FAFSA information) will be released, but only as allowed by the federal Higher Education Act.

**Acknowledgement of Understanding:**

- I understand that the student records information listed above includes information on me which is classified as private under Minn. Stat. §13.32 and the Federal Family Education Rights and Privacy Act. I understand that by signing this informed consent form, I am authorizing the release to the persons named above and their representatives information which would otherwise be private and not accessible to them. I understand that without my informed consent, the information described above could not be released because it is classified as private.
- I understand that when my records are released to the persons named above and their representatives, the College has no control over the use the persons named above or their representatives make of the records which are released.
- I understand that, at my request, the College must provide me with a copy of any educational records it releases to the persons named above pursuant to this consent. I understand that I am not legally obligated to provide this information and that I may revoke this consent at any time. This consent expires three years from the date signed or until I withdraw my consent, whichever comes first.
- A photocopy of this authorization may be used in the same manner and with the same effect as the original document.
- I am giving this consent freely and voluntarily and I understand the consequences of my giving this consent.

Student Signature \_\_\_\_\_ Dated \_\_\_\_\_

**Cancellation of Previous Authorization**

My signature below indicates my request to withdraw my previous authorization for release of information.

Student Signature \_\_\_\_\_ Dated \_\_\_\_\_