Please Print or Type	
Student Name:	Student ID Number:
Address: City/State/Zip Code:	School: Classification:
Telephone Number: Cell Phone (if available):	Email:

Person(s) or organization(s) to whom or to which records are to be released or disclosed, including the name, address, city/state/zip code, and telephone number of the person(s) or organization(s), and the person(s) or organization(s) relationship to student:

_____
_____

Item or Items that are to be released or disclosed (specify what is to be released):

_____
_____

Purpose or purposes for release or disclosure of educational records:

_____
_____

I hereby give my consent and grant authorization to the Texas Tech University Health Sciences Center (TTUHSC), including but not limited to Administrators, Faculty and Staff thereof, to release or disclose the educational records specified above to the party or parties named above. I further authorize that TTUHSC may discuss the information contained in the specified records with the authorized recipient(s). I hereby waive all provisions of the law and privileges related to the records described in this disclosure.

I understand that: I have the right not to consent to the release of my education records; I have

A signed copy of this Authorization may be used to the same extent as an original.

_____

_____
Student's Signature

Date Signed

_____
Witness Signature

_____
Witness Printed Name