Permission to Release - Parent

I hereby waive my rights to privacy under the Family Educational Rights and Privacy Act of 1974 (FERPA) and any other applicable law and consent to the release by the Office of Disability Services, Shippensburg University, of any and all educational records, recommendations and accommodations regarding me to my parents or guardians at their request. Information may be released to the following individual(s):

Name: ___________________________  Relationship: ___________________________

Name: ___________________________  Relationship: ___________________________

Name: ___________________________  Relationship: ___________________________

______________________________  __________________________
Student name (print)  SUID #

______________________________  __________________________
Student signature  Date