JEFFERSON COLLEGE of HEALTH SCIENCES

Registrar's Office
P.O. Box 13186
Roanoke, VA 24031-3186

Phone: (540) 224 - 4492 FAX (540) 224- 4562 Toll Free # to College 1 800 985 - 8483

STUDENT PERMISSION TO RELEASE INFORMATION

I, _____, give my permission

(Print Name Here)

to the individuals/office(s) checked here:

_____Academic Advisor _____Provost/Administrative Representatives
_____Bursar's Office _____Registrar's Office
_____Counseling Office _____Student Services
_____Financial Aid Office

To disclose information in my educational record at JCHS to the person(s) listed below:

1. _____ _____
Name of Person Relationship

2. _____ _____
Name of Person Relationship

3. _____ _____
Name of Person Relationship

The records which may be disclosed to the above-named individuals for the purpose of their review is limited to the following checked items:

_____ Academic Standing/Grades/ /GPA _____ Attendance and Enrollment
_____ Financial Standing _____ Health or Safety Emergency

_____

_____ I do not wish to restrict the time period covered by this release. It will be in effect for all periods of my enrollment at JCHS or until such time I decide to revoke or change it through the Registrar's Office.

_____I wish to restrict this release to a time period of

__ Current Semester __Current Academic Year __Other (specify)_____.

_____ This form is an update of a previously submitted form.

_____ _____
Student Signature Date

Revised 12/20/07