Student Request for Release of Educational Records

First Name:_________________ Last Name:________________________ Student ID:_____________

Email:__________________________ Graduate/Undergraduate:__________ Catalog Year:__________

Degree/Major:____ Date:________________

Under Federal legislation, namely the Family Educational Rights and Privacy Act of 1974, I understand that my educational record cannot be released without my written consent or a Parental Affidavit for Educational Record Release certified by my parent or guardian.

I therefore request that the information listed below be released to the following:

Name:____

Address:_________________________________ City:______________ State:_______ Zip:__________

Information to be released:

I understand that I must request for information each time it is needed.

Student Signature:______________________________________ Date:__________

Plymouth State University
of the University System of New Hampshire
Office of the Registrar
17 High St, MSC #7
Plymouth, NH 03264
Phone: (603) 535-2345 Fax (603) 535-2724