UNIVERSITY OF MIAMI
MILLER SCHOOL of MEDICINE

Office of Student Affairs P.O. Box 016960 (R-128) Miami, FL 33101 Ph: 305-243-2003 Fax: 305-243-8389

FERPA CONSENT FORM

Authorization for Release of Personal Information

FERPA, the Family Educational Rights and Privacy Act, protects the privacy of student education records. It gives students the right to review their educational records, the right to request to amend their educational records, and the right to limit disclosure from those records. For more information on FERPA, please visit the University of Miami's registrar website – http://www.miami.edu/index.php/about_us/hea_student_consumer_information/ferpa/

FERPA protected information includes, but is not limited to:

- Race
- Gender
- UM ID or Social Security Number
- Grades
- GPA
- Academic Standing
- Country of Citizenship
- Religion
- Financial Information

To authorize the release of FERPA-protected information, the student must complete this form and submit to the University of Miami Leonard M. Miller School of Medicine's Office of the Registrar.

STUDENT NAME (Last, First, Middle Initial):	EMPL ID or C Number:	DATE:

As required by the Family Educational Rights and Privacy Act of 1974, as Amended (FERPA) and Florida law, by my signature I hereby authorize the University of Miami Leonard M. Miller School of Medicine (UMMSM) to provide the University records noted upon this form to the parties identified below. **I understand the information may be released orally or in the form of copies of written records, as preferred by the requester. I have a right to inspect any written records released pursuant to this consent form. I understand I may revoke this consent form upon providing written notice to the UMMSM's Registrar Office. I further understand that until this revocation is made, this consent shall remain in effect and my educational records will continue to be provided to this individual or third party for the records noted.**

Records for which you authorize (Please Initial):	**This information is to be released for the following purpose (Please Initial):**
_____ Transcript and/or transcript related information _____ Academic Performance Information (e.g. grades, exam scores, academic standing, etc.) _____ Clinical Rotation Schedules _____ Bio-Demographic Information _____ MSPE (Medical Student Performance Evaluation) _____ Residency Status _____ All Records _____ Other (specify):__________________________	_____ Family communications about university experience _____ Employment _____ Admission to an educational institution _____ Other (please):___________________________ ____ ____

I hereby authorize the release of above records to:

Name of individual or third party: ____

Address of individual or third party: ____

Student Signature: _______________________________________ **Date:**_________________________