METRO STATE UNIVERSITY

Authorization to Grant or Revoke Access to Student Educational Records

Who needs to use this form? Students who wish to grant or revoke authorization for Metro State University to release their educational records. **To grant authorization, complete sections 1 and 2. To revoke it, complete sections 1 and 3**.

Important Notes: Consider which records the authorized party needs. It may not be prudent to allow complete access to all records. This consent is valid for the period indicated below or a maximum of one year or until consent is withdrawn (whichever occurs first).

How to Submit: Submit the completed form to the Gateway Student Services Center in-person or by mail.

SECTION 1: STUDENT INFORMATION

Last name _____ First name _____ Middle name _____

Metro State student ID number _____ Metro State email address _____ Phone number (with area code) _____

SECTION 2: AUTHORIZE ACCESS TO INFORMATION

I hereby authorize Metro State University to release and/or orally discuss my educational records (selected below) to:

Name _____ Organization _____ Department _____

Mailing address _____ Unit _____ City _____ State _____ ZIP _____ County _____

In order for Metro State University to verify the identity of the third party you have authorized, please indicate a password that the third party must provide when accessing the records selected below. It is your responsibility to communicate this password to the authorized third party (do NOT share your password with unauthorized parties). Password: _____

Educational records may be released and/or orally discussed between: _____ to _____ (MM/DD/YYYY, one year max.)

The specific records covered by this release are (select all that apply):

- ☐ All
- ☐ Grade reports at the end of the semester
- ☐ Bills and payments (e.g.: itemized charges, credits)
- ☐ Registration (e.g.: number of credit hours, add/drops)
- ☐ Financial aid (e.g.: awards, status)
- ☐ Other (please specify) _____

I understand that the student records information listed above includes information classified as private under Minn. Stat. § 13.32 and the Federal Family Education Rights and Privacy Act. I understand that by signing this Authorization to Grant or Revoke Access to Student Educational Records, I am authorizing the university to release to the persons named above and their representatives information that would otherwise be private and not accessible to them. I understand that, at my request, the university must provide me with a copy of any educational records it releases to the persons named above pursuant to this consent. I understand that I am not legally obligated to provide this information and that I may revoke this consent at any time. This consent is valid for the period indicated or a maximum of one year or until consent is withdrawn. During the authorized time period, this information will be released multiple times, as requested. A photocopy of this authorization may be used in the same manner and with the same effect as the original documents. I am giving this consent freely and voluntarily and I understand the consequences of my giving this consent.

Signature: _____ Date (MM/DD/YYYY): _____

SECTION 3: REVOKE ACCESS TO INFORMATION

I wish to revoke access to my education records for:

Name _____ Organization _____ Department _____

Signature: _____ Date (MM/DD/YYYY): _____

Contact us: **gateway@metrostate.edu** | **651.793.1300**

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