SUNY DOWNSTATE Medical Center

Office of the Registrar
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University Hospital of Brooklyn
College of Medicine
College of Nursing
College of Health Related Professions
School of Graduate Studies
School of Public Health

Authorization to Release Information Form

To: **The Office of the Registrar**

Date: _____

I, _____, hereby give permission to the Office of the Registrar
(Please Print)
to release to the following individual(s) information regarding my academic standing only:

Person Authorized	**Purpose**
_____	_____
_____	_____
_____	_____

I understand that it is my responsibility to notify the individual(s) listed above should there be any subsequent change in my academic standing.

_____ _____
Student Signature **mm/dd/yyyy**