Release of Information

Student Name _____ **PID #** _____

Local Address _____ **Local Phone Number** _____

Catmail Address _____ **Campus** _____

I authorize the Office of Student Services in the College of Health Sciences & Professions to release my academic information and related information to:

Name _____ **Relationship** _____

I understand that this authorization will be in effect for a period of one year from the date of my signature and that I need to submit a formal written request to terminate this authorization before that date.

Student Signature _____ **Date** _____

Witness _____ **Date** _____

Return to:

HSP Office of Student Services
370W Grover Center
1 Ohio University
Athens, OH 45701
740-593-9336
740-593-0285 (fax)
chspss@ohio.edu