|  |  |
| --- | --- |
| Student’s Name | PID Number |
|  |  |
| Local Address | Local Phone |
|  |  |
| OU Email Address |
|  |
| Campus |  |
|  |  |
|  | |
|  | |
| I authorize the staff in the Center for International Studies to release my academic 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 |
|  |  |