



Authorization for Release of Information
Carefully read this authorization to release information about you.

I authorize the following person(s) to obtain the indicated information below, relating to my activities as a student at Park University.

Individual #1 (print name)

Relationship to student

Security Question and Answer for Individual #1

Individual #2 (print name)

Relationship to student

Security Question and Answer for Individual #2

This information may include, but is not limited to:

- Academic
- Attendance
- Performance
- Account Info
- Disciplinary
- Residential
- Achievement
- Financial Aid

Understand, for financial or lending institutions, medical institutions, hospitals, health care professionals, and other sources of information, a separate specific release will be needed, and I may be contacted for such a release at a later date.

Copies of this authorization that show my signature are as valid as the original release signed by me. This authorization is valid from the date signed below and will continue in effect until my written termination.

Student Signature (signed in ink)

Date Signed

Full Name (Type or Print Legibly)

Student ID#

Cell Phone

Home Phone

Submit completed form to:
Park University SAC
8700 NW River Park Dr #15
Parkville, MO 64152
Fax: 816-505-5475