



House of Heavilin
BEAUTY COLLEGE

AUTHORIZATION FOR DISCLOSURE OF
PERSONALLY, IDENTIFIABLE INFORMATION

I, _____ Last 4 digits SSN: XXX-XX-_____ DOB: _____

House of Heavilin Beauty College, location _____
Former Name, if name change _____

I understand that, under the Family Educational Rights Privacy Act ("FERPA"), 20 U.S.C. 1232g, generally the College may not disclose or release personally identifiable information concerning me or my attendance at the College to other persons. I further understand that FERPA allows me to authorize the College to make disclosure of some or all, of such information, if I choose to do so. By signing this authorization form on the date listed below and in the presence of the witness identified below, I hereby confirm that, for the reasons hereafter stated, I have chosen and do hereby authorize the College to release to the person(s) identified below and through the means designated, the information and records identified below.

(1) Person(s) To Whom Disclosure is Authorized: (the persons you would like sent too)

Name
Address
City, State, Zip
Telephone Fax e-mail
Relationship

(2) Records/Information for Which Disclosure is Authorized: (Please Initial applicable items)

Grades Financial Aid
Attendance Counseling/Behavior
Other (Please specify) Official Transcript

(3) Authorized Means of Disclosure (specify mail, fax, or e-mail):

(4) Purpose for Which Disclosure is Authorized:

Student Signature _____ Date _____

Name Printed _____ Address _____

City, State, Zip _____

Witnessed By:
Name & College Position _____ Date _____

Please fax to 816-817-4510 -- or email attachment to - aodonnell@kc-hair.com * please allow 3 business days to process