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
_____ Attendance
_____ Other (Please specify)
_____Financial Aid
_____Counseling/Behavior
_____ 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 - mandy@kc-hair.com** * please allow 3 business days to process