

# Release of Information Consent Form



**Registrar's Office**  
62 York Street, Sackville, NB  
Canada, E4L 1E2  
(506) 364-2269 (phone)  
(506) 364-2272 (fax)

Last Name	First /Preferred Name	Middle Name	E-mail Address	Phone Number ( )	Student ID #

I hereby grant permission to Mount Allison University to release the following information to the person(s) named below:

**PERMISSION IS GRANTED TO RELEASE THE FOLLOWING INFORMATION:**

Please check the appropriate box(es):

- All information
- Academic information
- Financial information
- Only the information specified here:

\_\_\_\_\_ *(Please indicate)*

**TO THE FOLLOWING PERSON(S):**

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

**FOR THE FOLLOWING PERIOD OF TIME:**

- For the duration of my time at Mount Allison University
- 20\_\_/20\_\_ Academic Year
- From \_\_\_\_\_, \_\_\_\_\_ to \_\_\_\_\_, \_\_\_\_\_  
Month Year Month Year

**Student Signature** \_\_\_\_\_ **Date** \_\_\_\_\_

**Witness of Student Signature** \_\_\_\_\_ **Relationship** \_\_\_\_\_ **Date** \_\_\_\_\_