Release of Information Consent Form

Registrar's Office
62 York Street, Sackville, NB
Canada, E4L 1E2
(506) 364-2269 (phone)
(506) 364-2272 (fax)
regoffice@mta.ca (email)

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):

- ❑ Any of my student information (please note Mount Allison University does not release account username & password information)
- ❑ Academic information only (excluding grades; students must request a transcript to release their grades to a third party)
- ❑ Student financial account information only
- ❑ Only the information specified here:

_____
(Please indicate)

TO THE FOLLOWING PERSON(S) UPON REQUEST:

Name: _____ Contact information (email/Phone): _____

Name: _____ Contact information (email/Phone): _____

Name: _____ Contact information (email/Phone): _____

FOR THE FOLLOWING PERIOD OF TIME:

❑ until such time as I revoke permission (contact Registrar's Office)

❑ for the duration of my time at Mount Allison University

❑ for the 20_ _/20_ _ Academic Year

❑ From _____, _____ to _____, _____
Month Year Month Year

Student Signature **Date**

_____ _____

Witness of Student Signature (Registrar's Office Staff or other person known by the student who is not a relative or named above) **Date**

_____ _____

_____ _____
Print name contact information (email/phone)