

**COLLEGE OF ARTS AND SCIENCES
INDIANA UNIVERSITY**

PERMISSION TO RELEASE INFORMATION FROM ACADEMIC FILES

I give my permission for an academic assistant dean of the College of Arts and Sciences to discuss my academic record and any other information in my academic files with

Name and/or title of person(s) to whom information may be released

This permission is considered to be in effect until rescinded by me in writing.

If there is any specific information which may not be released to the above-named party, please note it here:

Student's signature: _____ Date: _____

Student's name (please print): _____

Student's 10-digit ID Number: _____

PLEASE RETURN THIS FORM TO THE COLLEGE OF ARTS AND SCIENCES ACADEMIC ASSISTANT DEANS OFFICE – KIRKWOOD HALL 012

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