Permission for Release of Information

Date: _____

I, _____, authorize the **Center for Student Academic Support** to release the following information:

_____

_____

_____

_____

_____

The information will be made available to the following persons/offices:

1. _____
2. _____
3. _____

_____
Student Signature

_____
Street Address

_____
City, State, Zip

_____
Phone Number

_____
Staff Member of CSAS
Fax #918-631-3459

Notice: This information has been disclosed for records which are confidential. Any further disclosure without the specific written consent of the person to whom it pertains exceeds the limits of this release.