

AUTHORIZATION TO RELEASE INFORMATION FORM

STUDENT AUTHORIZATION TO RELEASE

(PLEASE PRINT CLEARLY)

Student's Name: _____
First Middle Initial Last

Social Security # or MU ID: _____ Date of Birth: ____/____/____

Pursuant to the provisions of the Privacy Act of 1974 (5 USC 552a, PL 93-579, as amended), I hereby authorize the Office of Financial Aid to release information from my financial aid file and any other record pertaining to me to the individuals listed below. **I understand and agree that the information released will cover my entire academic career at Millersville University and I may change it at any time by completing a new Authorization to Release Information Form, at which time any prior forms signed by me will become null and void.** I understand that my information may be released to Millersville University Registrar's Office and/or Bursar's Office. I also understand that the released information may be electronically transferred by the Office of Financial Aid or its agents. In addition, I understand that the individual(s)/agency that I have designated below must verify my social security number or Millersville University Identification number and my date of birth before any information is released to them.

INDIVIDUAL(S)/AGENCY TO RECEIVE INFORMATION

I WISH TO HAVE NO ONE OTHER THAN MYSELF BE ABLE TO ACCESS ANY FINANCIAL AID INFORMATION.

I grant access to the following individuals/agencies: PLEASE Print
(All fields related to the individual/agency selected are REQUIRED. Incomplete forms will not be processed.)

MOTHER Name: _____

FATHER Name: _____

STEPMOTHER Name: _____

STEPFATHER Name: _____

SPOUSE Name: _____

AGENCY Name: _____ Phone: ____-____-____

OTHER Name: _____ Relationship: _____

OTHER Name: _____ Relationship: _____

Student's Signature: _____ Date: ____/____/____

PLEASE ALLOW 3 – 5 BUSINESS DAYS FOR PROCESSING.

Please return this form by mail to: **Millersville University
Office of Financial Aid
PO Box 1002
Millersville PA 17551**