Cleveland Clinic
School of Health Professions

FERPA Release Authorization

I, _____, authorize Cleveland Clinic's School of Health Professions to disclose the following education records:

- ☐ Transcript, including grades and courses taken
- ☐ Test/exam scores
- ☐ Courses taken
- ☐ Attendance records
- ☐ Disciplinary records
- ☐ Medical and health records created and collected by Cleveland Clinic and/or academic institution
- ☐ All records
- ☐ Other: _____

to the following named individuals or entities:

for the following purpose:

- ☐ Household/parental/legal guardian communications about academic/training performance
- ☐ Employment
- ☐ Admission to another academic or training institution
- ☐ Other: _____

beginning on the date of: _____

☐ ending on the date of: _____

OR

☐ until revoked by me

Student Name: _____ **Date:** _____

Student Signature: _____

This form must be completed prior to release of student information beyond directory information as allowed by FERPA, including verbal, physical, and electronic forms of communication.

Last update: 5/1/2025