

AUTHORIZATION FOR RELEASE OF CONFIDENTIAL INFORMATION TO PARENT(S)

Please return this Authorization Form to the Office of the Registrar, Lownik 103, scan in and email to bencentral@ben.edu, or FAX to 630-829-6663

| | Student ID Number | |
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| Daniel Addie | 0 | Academic Academic |
| Permanent Street Address | City State Zip Code | Financial |
| | nd Privacy Act (FERPA), Benedictine University ducation records to parent(s) if student consents to | |
| UDENT CONSENT | | |
| be completed annually) | | |
| | sonally identifiable information from my educed determined by Benedictine University as appro- | |
| | demic year only or until I revoke it in writing. | 1 |
| SIGNED: | Date:t be hand-written on the form* | |
| | t be hand-written on the form* | |
| Please print. | | |
| Name/Relationship | Name/Relationship | |
| | | |
| Address | Address | |
| City, State, Zip | City, State, Zip | |
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| | Telephone e disclosure of information from my Education | n Records to my |
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