

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 #Registrars@ben.edu, or FAX to 630-829-6663

PRINT Student's Name		Studer	nt ID Number	Please check:
D	01	7: 0		Academic Academic
Permanent Street Address	City	State Zip Co	ode	Financial
Under the Family Education disclose information from a				
UDENT CONSENT				
be completed annually)			C 1	
A. I <u>allow</u> the disclosure parent(s) named below, f				
will remain in effect for the				
SIGNED:		D	ate:	
Please print.		-		
Name/Relationship		Name/Rela	ti a malaina	
Name/ Relationship		Name/ Reia	uonsnip	
Address		Address		
City, State, Zip		City, State,	Zip	
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