



Authorization for Release of Information

Name _____ ID# _____

Date of Birth _____ Local Phone # _____

Local Address _____

Permanent Address _____

I request and authorize employees of the Financial Aid Office at the University of Wisconsin-Whitewater to disclose any and all information regarding my financial aid and/or my student account at the University of Wisconsin-Whitewater to my parents, legal guardians, and/or spouse. This information should be released for the purpose of assisting in the payment of my University obligations.

This authorization is in effect until written notification rescinding this release has been received.

I authorize that a photocopy of this authorization be accepted with the same authority as the original.

(Signature)

(Date)