American University of St. Vincent- School of Medicine
Office of Student Records
5999 Summerside Drive, Suite 240, Dallas, Texas, USA 75252
http://www.ausmed.us
registrar@ausmed.us
Phone: 469-941-4940
Fax: 469-941-4941

Authorization for Access to Student Educational Records

Student Information

Last Name	First	Middle	Student ID Number

Permanent Address	Apt. No.	City	State	Zip Code	Country

Primary Telephone #	Email Address
( )	

The American University of St. Vincent is permitted to disclose personally identifiable information from your educational records only with your written authorization.

Please grant access to my educational records to the following person/people:

	First Name	Middle Name	Last Name
Authorization 1:			
Authorization 2:			

I understand that the information which can be released includes grade records, class attendance records, employee status, conduct records, financial records, educational progress assessments, and information pertaining to citizenship in the community.

This authorization will remain in effect at all times during which I am a student at AUS unless it is specifically withdrawn in writing to the Office of Student Records.

Student Signature	**Date**

❖❖❖❖❖❖ OFFICE USE ONLY *(Please do not write in this space)* ❖❖❖❖❖❖

Date Received:	Date Processed:	Approved By:
/ /	/ /	