NEW YORK MEDICAL COLLEGE

A MEMBER OF THE TOURO COLLEGE AND UNIVERSITY SYSTEM

New York Medical College - Office of the Registrar

40 SUNSHINE COTTAGE ROAD, VALHALLA, NEW YORK 10595

Student Records FERPA WAIVER

______________________________ Name of Student (Last, First Middle Initial) | ______________________ NYMC #ID | ______________________ Phone Number

FERPA

The Family Educational Rights and Privacy Act (FERPA) of 1974 establishes the rights of students with regard to educational records. The act makes provision for inspection and review of educational records by the students and requires, in most instances, prior consent from the student for disclosure of such records to third parties. The consent must be in writing, signed and dated by the student, and include the names of the parties to whom such records can be accessed. The Act applies to all persons formerly and currently enrolled at an educational institution. Access to educational records does not give permission to make changes to the student's record.

By signing this waiver, the student is voluntarily granting to the designated individuals, access to confidential records within said student's educational file.

I ____________________________________(print student name) voluntarily hereby give permission for NYMC personnel to share and discuss the following information (check all that apply):

- ☐ Records maintained by the Office of the Bursar (account balance, billing, collection activity, etc.)
- ☐ Records maintained by the Financial Aid Office (grants, scholarships, student loans, etc.)
- ☐ Records maintained by the Office of the Registrar (academics, grades, GPA, attendance, reports, evaluations, etc.)
- ☐ ALL OF THE ABOVE
- ☐ OTHER (please specify):____

The purpose of this disclosure is to: ____

Person(s) to whom above information may be released. Please PRINT clearly.

Name (Last, First):_______________________ Relationship to student:☐Parent* ☐Spouse ☐Attorney ☐Other_________

Name (Last, First):_______________________ Relationship to student:☐Parent* ☐Spouse ☐Attorney ☐Other_________

* In the event the "☐Parent" box is checked, then information may be released to all parents or guardians regardless of the individual name listed.

Check one:

___ This waiver will be in effect as long as I am a student at NYMC.

___ This waiver will be in effect from: (Date)_____________ until: (Date)____________

This waiver may be revoked by the student at any time by advance written notice to the Office of the Registrar.

SIGN and DATE:
Signature:____ **Date:**_________

Please return this form to the Office of the Registrar, NYMC in person or by mail.
Waivers received via mail must be ratified by NYMC with an email to the student and the student's confirmation.
Proper photo identification will be required for form submission as well as access.
Due to stringent security concerns, any waivers initially submitted via electronic mail will not be processed.

For Institutional Use Only

Processed by:____ Date: ________________