

UNIVERSITY OF FLORIDA COLLEGE OF MEDICINE
INFORMATION RELEASE REQUEST

STUDENT _____ UFID# _____ - _____

PHONE # _____ - _____ - _____ CELL PHONE # _____ - _____ - _____

ADDRESS _____

CITY _____ STATE _____ ZIP _____

EMAIL ADDRESS _____

I UNDERSTAND BY REQUESTING INFORMATION ELECTRONICALLY FROM THE FINANCIAL AID OFFICE AT THE COLLEGE OF MEDICINE, THEY CAN NOT GUARANTEE COMPLETE SECURITY OF THAT INFORMATION.

I REQUEST MY INFORMATION BE RELEASED TO THE FOLLOWING PERSON

NAME _____ SS# _____ - _____ - _____

RELATIONSHIP TO STUDENT _____

PHONE # _____ - _____ - _____ DATE OF BIRTH _____ / _____ / _____

ADDRESS _____

CITY _____ STATE _____ ZIP _____

EMAIL ADDRESS _____

(STUDENT SIGNATURE)

(DATE)