



Authorization to Release Information

Student Name: _____ UIN: _____
Address: _____ Email: _____
Phone: (____) _____

Authorized Parties

Name: _____ Relationship: _____
Name: _____ Relationship: _____
Name: _____ Relationship: _____
Name: _____ Relationship: _____

I authorize the Office for Student Conflict Resolution (OSCR) to disclose to the above Authorized Parties the information indicated below. Check all that apply:

- Releasable information about any OSCR case in which I am the respondent (accused student)
Releasable information about any OSCR case in which I am a complainant and/or alleged victim
Releasable information about a specific OSCR case in which I am an involved party
Case/Incident Number (if known) or Incident Date: _____
Other: _____

I understand the content and nature of the material that is to be disclosed. I understand that I have the right to revoke this consent but that my revocation is not effective until delivered in writing to the Office for Student Conflict Resolution. I understand that the Office for Student Conflict Resolution reserves the right to require that I be present, or otherwise directly involved, when information is disclosed.

Student Signature

Date