

SPELMAN COLLEGE

OFFICE OF FINANCIAL AID

350 Spelman Lane

Packard Hall, Lower Level

Atlanta, GA 30314

404-270-5222 (office)

404-270-5220 (fax)

STUDENT AUTHORIZATION TO DISCUSS FINANCIAL AID INFORMATION

STUDENT NAME _____ SPELMAN ID# _____

The Family Educational Rights and Privacy Act (FERPA) of 1974 is a federal law, which prohibits the disclosure of a student’s educational record, including financial aid information, without written consent of the student. By signing this authorization, you consent to have our office personnel discuss your financial aid record for the current academic year, including but not limited to your type of financial aid awards, your (and if applicable, your parent or spouse) income and assets, and your satisfactory academic progress standing.

To facilitate the authorization of these individuals, the student must complete this form and return it to our office by mail, email (financialaid@spelman.edu) or fax (404-270-5220). **If the student does not submit the form in person, the student must include a legible copy of her Spelman ID or a photo ID with the request.**

AUTHORIZE THIRD PARTY DISCLOSURE ONLY FILL OUT AND SIGN ONE PART

I authorize the disclosure of information related to my financial aid record to the individuals noted in Part I. The Financial Aid Office will confirm with the authorized party their name, relationship and last 4 of SSN before releasing any information. Please include all three identifiers on the form. .

PART I - AUTHORIZATION

- 1. Name _____ Relationship _____ Last 4 of SSN _____
- 2. Name _____ Relationship _____ Last 4 of SSN _____

STUDENT SIGNATURE _____ DATE _____

OR **PART II – DENIAL OF AUTHORIZATION**

I choose not to authorize the release of my financial aid information to any third party.

STUDENT SIGNATURE _____ DATE _____

OR **PART III – REVOKING AUTHORIZATION**

I hereby **REVOKE** the right of the individual(s) listed below to receive any information concerning my financial aid. I am aware the individuals will be notified of the revocation of this authorization.

- Name _____ Relationship _____
- Name _____ Relationship _____

STUDENT SIGNATURE _____ DATE _____

This form will be kept on file for **one academic year** and authorizes the indicated parties to have access to discuss your financial aid record. Please note this form must be updated annually.

Limited information will be released by telephone.