



# Consent to Release School Records

This form is provided by **Cecil Community College** for the purpose of releasing academic and/or financial records for the following student:

Name of Student \_\_\_\_\_

Date of Birth \_\_\_\_\_

Social Security # \_\_\_\_\_

College ID # \_\_\_\_\_

I hereby authorize **Cecil Community College** to release school records for the above named student to:

Name of High School \_\_\_\_\_

Address \_\_\_\_\_

City, State, Zip Code \_\_\_\_\_

The purpose for which these records will be used:

**Admissions, academic monitoring, transcripts and other personally identifiable information as requested.**

INFORMATION DISCLOSED UNDER THIS AUTHORIZATION MAY NOT BE DISCLOSED TO ANY OTHER PARTY WITHOUT THE PRIOR WRITTEN CONSENT OF THE STUDENT.

***Please return to:***

Registrar/ESSS Services  
 Cecil Community College  
 One Seahawk Drive  
 North East, MD 21901

\_\_\_\_\_  
(Date)

\_\_\_\_\_  
(Student Signature)

\_\_\_\_\_  
(Address)

\_\_\_\_\_  
(City, State, Zipcode)