ECSU
ELIZABETH CITY STATE UNIVERSITY

Division of Academic Affairs

CONSENT FORM

_____
Date

_____ _____
Student's Name (Please Print Legibly) Student's ID Number

I hereby authorize the person(s) named below to obtain academic and/or other information as it relates to my student record at Elizabeth City State University. This form will only be valid if the student is in active status at the time of consent. This form will remain valid until the student graduates and can only be revoked by the student.

[The University adheres to the established rules on the confidentiality of students records in accordance with the provisions of the Family Education Rights and Privacy Act of 1974 (P.I, 93-380), commonly referred to as the Buckley Amendment.]

_____
Student's Signature

Name and address of person(s) who will receive information:

_____	_____
Name	Name
_____	_____
Address	Address
_____	_____
City, State, Zip Code	City, State, Zip Code
_____	_____
(Area Code) Telephone Number	(Area Code) Telephone Number

Return completed form to:
Office of the Registrar, CB 953
Elizabeth City State University
1704 Weeksville Road
Elizabeth City, NC 27909
Or Fax to: (252) 335-3729