



Elizabeth City State University  
Division of Academic Affairs

CONSENT FORM

\_\_\_\_\_  
Date

\_\_\_\_\_  
Student's Name (Please Print Legibly)

\_\_\_\_\_  
Student's ID Number

I hereby give permission to the person(s) named below to receive academic and/or other information about me from 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