

## Authorization Form for Release of Information

### COMPLETE SECTION A:

#### A. Identification

This document authorizes the use and/or disclosure of confidential protected information about the following person:

Student Name:

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Address: \_\_\_\_\_

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

Daytime Phone Number: (        ) \_\_\_\_\_

Name of People to Release Information and ID#

**Education Council of the Cayman Islands as I am on government scholarship, and this is required of my scholarship.**

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#### B. Directions for Release

This authorization applies in accordance with my directions as checked below. I authorize UCCI to release my information pertaining to the people listed in Section A.

**Check what you want released below:**

**I authorize the disclosure of the following information:**

Grade Reports

Transcripts

Attendance

Timetable

Financial Statements

All Records

Other Information (List Below)

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#### C. Right to Revoke:

I understand that I may revoke this Authorization at any time except to the extent that action has already been taken in reliance upon it. If I do not revoke it, this Authorization will expire one (1) year after the date on which the Authorization is signed. To revoke the Authorization, I understand I must contact the following in writing: Registrar, UCCI PO BOX 702 GT, Grand Cayman or via fax to (345) 949-6781.

**You Must Continue on the Next Page**

**YOU AND A WITNESS MUST SIGN IN SECTION D:**

**D. Authorization and Signature:** I authorize the release of my confidential protected student information, as described in my directions in Section B. I understand that this authorization is voluntary, that the information to be disclosed is protected, and the use/disclosure is to be made to conform to my directions.

I, \_\_\_\_\_, have read the contents of this Authorization, and I confirm that the contents are consistent with my directions. I understand that by signing this form, I am authorizing the use and/or disclosure of my confidential protected health information.

\_\_\_\_\_  
Your Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Witness

\_\_\_\_\_  
Date

**Complete, Sign and Return this form to: Registrar, UCCI PO BOX 702 GT, Grand Cayman or fax to (345) 949-6781.**

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