

PERMISSION TO RELEASE INFORMATION

Records Office - Jackson State Community College

2046 North Parkway Jackson, TN 38301

Phone: (731) 425-2654 Fax: (731) 425-2653

Name _____
Last First Middle

JSCC Campus ID # _____ Semester _____ Year _____

I request that the person(s) listed below (whom I have designated) have access to my academic records.

Name: _____
Last First Middle Relationship

Name: _____
Last First Middle Relationship

*The listed individual(s) must present a valid photo ID (e.g. driver's license) to the Records Office when seeking information. **No non-directory information will be given over the phone.

This is effective for only the current semester for which I am registered. I understand that submitting a signed form to the Records Office means that any future requests for information by the listed person(s) during the applicable semester will honored.

JSCC assumes no liability for honoring your instructions to release information.

Student Signature _____ Date _____

Records Office Use Only

Date Entered _____ Records Staff _____