RELEASE FORM

MD/MPH Dual Degree Program

The Family Educational Rights and Privacy Act of 1974 (FERPA), protects personally identifiable information in student education records (such as the student's name, address, financial records, and grades) from disclosure without the student's signed, written consent unless such consent is not required by law.

This authorization form will allow officials at the University of Texas at Austin Dell Medical School and the UTHealth School of Public Health to receive and exchange the following information or category of information.

I, _____, hereby authorize the University of Texas at Austin Dell Medical School and the UTHealth School of Public Health to disclose the following records for the purpose of facilitating dual degree enrollment:

- Criminal Background Check Results
- Student Account Information
- Academic Transcripts

I understand that this authorization may be revoked in writing at any time, unless action has already been taken based upon it, and that in any event this authorization expires upon the date of my graduation from Dell Medical School.

I represent that I am at least 18 years of age, have read and understand the foregoing statement, and am competent to execute this agreement.

Name: _____

Address: _____

Phone: _____

Date: _____

Signature: _____