LSUE
Division of
Student Affairs

Authorization for Release of Student Information

Student Information

Student Name: _____

Student ID Number: _____

Date of Birth: _____

Education Institution Name: _____

Purpose of Authorization

In compliance with applicable privacy laws, including the Family Educational Rights and Privacy Act (FERPA), this form authorizes the above-named institution to communicate information, as permitted by law, to my parent(s), guardian(s), or other designated individuals regarding matters that may impact my academic progress, personal safety, wellbeing, or overall participation in the institution. This may include, but is not limited to, academic concerns, health or mental health issues, behavioral concerns, emergency situations, or circumstances in which I may pose a risk to myself or others.

Section 1: Designated Contact(s)

I hereby authorize the institution to contact the following individual(s):

Primary Contact Name:*

First Name _____

Last Name _____

Relationship to Student: * _____

Phone* _____

Email* _____

Secondary Contact Name:

First Name _____

Last Name _____

Relationship to Student: _____

Phone _____

Email _____

Section 2: Scope of Information to Be Shared

I authorize the education institution to share the following types of information with the designated contact(s):

- General nature of the mental health crisis.
- Actions taken by the education institution (e.g., hospitalization, counseling referral).
- Recommendations for follow-up care.

Note: Specific diagnoses or treatment details will not be disclosed unless otherwise authorized or required by law.

Section 3: Duration of Authorization

This authorization will remain in effect (**please select one**):*

[ ] Until the conclusion of my enrollment at the education institution

[ ] Until I submit a written request to revoke this authorization

Section 4: Student Acknowledgment

I understand the following:

- I am voluntarily granting this authorization.
- I have the right to revoke this authorization at any time by submitting a written request to the education institution.
- Revocation of this authorization will not apply to information already shared under this consent.
- This authorization does not require the education institution to notify my designated contact(s) unless deemed necessary.

Signature of Student: _____

Date: _____

Section 5: College Representative Acknowledgment

Signature of Representative:

_____

Printed Name:

_____

Title:

_____

Date: _____

Privacy Notice

The information disclosed under this authorization is protected by federal and state privacy laws. The education institution will use reasonable efforts to safeguard your information in accordance with these laws.