



**Tai Sophia
Institute**

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Laurel, MD 20723
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301-725-1674
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Consent to Release Educational Records

Pursuant to the Family Educational Rights and Privacy Act, I do hereby consent to Tai Sophia Institute releasing for inspection, providing copies, and/or otherwise disclosing, whether verbal or in writing, whether opinion or fact, any and all of my student educational records as identified below:

- | | |
|---------------------------------------|------------------------------------|
| <input type="checkbox"/> All Records | <input type="checkbox"/> Academic |
| <input type="checkbox"/> Disciplinary | <input type="checkbox"/> Financial |
| <input type="checkbox"/> Scholarship | <input type="checkbox"/> Degree |

If release is for specific records only, please identify:

I authorize Tai Sophia Institute to release records to the following (list names separately):

- Parent _____
- Parent _____
- Employer _____
- Insurance Company _____
- Student Loan Lender _____
- Other _____

I understand that this consent shall remain in effect until my written revocation is delivered to the Registrar's Office, and that such revocation shall not affect disclosures made by Tai Sophia Institute prior to the receipt of any such written notice.

Signature _____ Date _____