



Department of Enrollment Services

PO Box 729  
Milwaukee, WI  
53201-0729  
414 229-6431 *phone*  
414 229-6940 *fax*

## Consent to Disclose Records

I, \_\_\_\_\_ hereby request and authorize  
(Name of Student)

\_\_\_\_\_ to disclose and transmit to  
(Name of UWM Office)

\_\_\_\_\_  
(insert name of recipient of education records/or class of parties to whom disclosure may be made)

a copy of the following educational records:

\_\_\_\_\_  
(describe in detail)

for the purpose of \_\_\_\_\_  
(indicate purpose)

I understand that I can also obtain a copy of the above indicated records if I desire.

\_\_\_\_\_/\_\_\_\_\_  
(Signature of Student) (Date)