



**ALBANY**  
Technical College

1704 S. Slappey Blvd. ▲ Albany, Georgia 31701 ▲ Tel# (229) 430-5281 ▲ Fax (229) 430-6180

**STUDENT AUTHORIZATION FOR RELEASE OF RECORDS  
TO PARENTS OR GUARDIANS**

STUDENT NAME: \_\_\_\_\_  
Last First Middle

STUDENT I.D. or SSN#: \_\_\_\_\_

**I hereby authorize Albany Technical College to release information contained in my student records to my parents or guardians listed below upon receipt of their written request, or upon the determination of appropriate college officials. I understand that this authorization will remain in effect until I submit the necessary changes, in writing, or to the Registrar's Office.**

**(Student must submit this form with proper ID).**

\_\_\_\_\_  
Student Signature (required) Date

Parent/Guardian Name _____ Last First Middle		
Address: _____ Street Address		
_____	_____	_____
City	State	Zip-code

Parent/Guardian Name _____ Last First Middle		
Address: _____ Street Address		
_____	_____	_____
City	State	Zip-code

**(Picture ID required for release of students records)**