

SOUTHERN CALIFORNIA COLLEGE OF OPTOMETRY  
2575 Yorba Linda Blvd.  
Fullerton, California 92831

**REQUEST FOR RELEASE OF RECORDS FOR FORMER STUDENTS**

Name: \_\_\_\_\_ Class of \_\_\_\_\_ Date: \_\_\_\_\_

Please specify records to be released:

\_\_\_\_\_ Transcripts

\_\_\_\_\_ Information relating to Clinical Performance/Skills

Please specify: Name of Faculty member to respond \_\_\_\_\_

\_\_\_\_\_ Other: Please specify \_\_\_\_\_

Please specify purpose of disclosure: \_\_\_\_\_

Print name of person, office or college \_\_\_\_\_  
to receive copy of transcripts and \_\_\_\_\_  
complete address, including zip code. \_\_\_\_\_

*Requestor assumes full responsibility for furnishing the complete and current address.  
Transcript fee - \$20 per copy.*

*I understand that (1) I have the right not to consent to the release of my education records; (2) I have the right to receive a copy of such records upon request; (3) and that this consent shall remain in effect until revoked by me, in writing and delivered to SCCO, but that any such revocation shall not affect disclosures previously made by SCCO prior to the receipt of any written revocation.*

\_\_\_\_\_  
*Signature*

THIS INFORMATION IS RELEASED SUBJECT TO THE CONFIDENTIALITY PROVISIONS OF THE FAMILY EDUCATION RIGHTS PRIVACY ACT (FERPA) AND OTHER APPROPRIATE STATE AND FEDERAL LAWS AND REGULATIONS WHICH PROHIBIT DISCLOSURE OF EDUCATIONAL INFORMATION WITHOUT THE SPECIFIC WRITTEN CONSENT OF THE PERSON TO WHOM IT PERTAINS, OR AS OTHERWISE PERMITTED.

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FOR OFFICE USE:

MAILED: \_\_\_\_\_

PICKED UP: \_\_\_\_\_