

The University of Texas Health Science Center at San Antonio

Office of the Registrar

REQUEST TO REVIEW EDUCATION RECORDS

Name of Student: _____

Student HSC ID#: _____

Purpose of Review: _____

Item(s) of information requested: _____

Name of Requester: _____

Title: _____

Department: _____

HSC ID #: _____

I agree to keep the information disclosed to me, through the review of student records, confidential according to the federal Family Educational Rights and Privacy Act of 1974 (FERPA).

Signature: _____ Date: _____