POZNAN UNIVERSITY OF MEDICAL SCIENCES
CENTER FOR MEDICAL EDUCATION IN ENGLISH

41 , Jackowskiego Str.
60-512 Poznań, Poland
www.pums.edu.pl

Phone: + 48 61 854 71 43, -71 47
Fax: + 48 61 847 74 89
E-mail: pums@pums.edu.pl,
cnja@ump.edu.pl

Financial Aid Information Disclosure

Student Consent Form

Student Name: _____

The Family Education Rights and Privacy Act (FERPA) (20 U.S.C. § 1232g; 34 CFR Part 99) is a federal law that protects the privacy and confidentiality of student records. Schools must have written permission to release student record information.
If you wish to authorize the Bursary Office of the Center for Medical Education in English at Poznan University of Medical Sciences and the Office of Center for Medical Education in English at Poznan University of Medical Sciences to disclose information to a designated individual (e.g. parents, siblings, spouse, etc.) you must sign and date this form.

By signing this request, you, the student, certify that you are granting the Bursary Office and/or the Office of Center for Medical Education in English at Poznan University of Medical Sciences permission to release your information to the authorized individuals indicated below.

This disclosure is valid only for financial aid and student account information.
If you, the student, wishes to revoke the authorization, you must provide a written statement to the Office of Financial Aid.

For more information regarding FERPA, visit:
https://www2.ed.gov/policy/gen/guid/fpco/ferpa/index.html

I authorize the Bursary Office and/or the Office of Center for Medical Education in English at Poznan University of Medical Sciences to disclose information regarding my financial aid and/or student account to my agent(s) while I attend Poznan University of Medical Sciences.

Name of Authorized Agent(s): ***(Please print.)***

Michał Pasikiewicz
Beata Matyszewska

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Student Signature:_____Date____/____/____