VIRGINIA
HEALTH CARE
FOUNDATION

707 East Main Street, Suite 1350 • Richmond, VA 23219 • **www.vhcf.org**
Phone: (804) 828-5804 • Fax: (804) 828-4370 • email: info@vhcf.org

FERPA CONSENT TO RELEASE INFORMATION

The Family Education Rights and Privacy Act of 1974 (*FERPA*) states that a student must authorize in writing the release of his/her educational records.

Please complete and sign this form to authorize release of your educational records and/or allow the Virginia Health Care Foundation (*VHCF*) to communicate with the university noted below regarding your Psychiatric-Mental Health Nurse Practitioner program. VHCF must have a signed authorization on file to administer its Psychiatric-Mental Health Nurse Practitioner scholarship program.

Restrictions or permissions related to the sharing of education records may extend to alumni as well, so this authorization will remain in effect indefinitely until the individual submits a change, in writing, to the Foundation.

University: _____

I, the undersigned, understand that information may be released to the Virginia Health Care Foundation orally or in the form of written records, as preferred. I understand this authorization remains in effect until otherwise revoked by me.

Student Name (*print*): _____

Student Signature: _____

Student Social Security Number: _____

Student Phone Number: _____

Student email (*personal*): _____

Date: _____

Please return this completed form to the Virginia Health Care Foundation with your scholarship application.