



FAX Release of Information Form 2017-18

To be completed by the student and FAXED to our office at 260.665.4511

Student Name _____

Last 4 digits of Social Security Number SSN XXX-XX- _____

Home Mailing Address _____

City _____ State _____ Zip _____

Telephone Number _____

Email Address _____

I, _____, give consent to have financial aid information released via FAX to the following people or organizations:

Name of Person or Organization	FAX Number
_____	(_____) _____
_____	(_____) _____
_____	(_____) _____
_____	(_____) _____
_____	(_____) _____

By signing this document, I give the Office of Financial Aid permission to release information to the above named parties (including myself) in the form of a fax. I understand that I can rescind any portion of this authorization via FAX at any time. I understand that this authorization form is valid for my entire career at Trine University.

Student Signature _____ Date _____