REGISTRAR'S OFFICE

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Morrilton, AR 72110

(501) 977-2052
Fax: (501) 354-7566
registrar@uaccm.edu

www.uaccm.edu

STUDENT ACADEMIC RECORDS STATEMENT OF ACCESS

Name: _____ **I.D./S.S. No.** _____
(Last Name) (First Name)

Please consider this statement as my written permission to allow the following individual to have access to my academic records maintained by the Registrar's Office.

Type of Access: (Please initial your preference)

_____ **Restricted view access to records indicated below:**
(Initial)

_____

_____

_____ **Permission to transport records indicate below:**
(Initial)

_____

_____

Name: _____ **Relationship:** _____

Must show photo ID at time of access.

NOTE: This access can only be permitted after proper identification or signature is provided and this form is approved by the Registrar's Office.

Signature: _____ **Date:** _____

Unless revoked, this form will be valid for one academic year (August 1-July 31).

Students have the right to revoke this form at anytime by contacting the Registrar's Office.

☐ **Revoked**

Signature: _____ **Date:** _____

Signature: _____ **Date:** _____
(Registrar's Office)