



# United States Department of Education

## Certification of Identity & Authorization to Disclose Personal Information

**Privacy Act Statement.** Department regulations require a person who submits a written request for access or disclosure of records to submit personal data sufficient to identify the individual submitting the request. 34 C.F.R. Section 5b.5(b). We solicit the information requested here in order to ensure that the records of individuals who are the subject of Department systems of records are not wrongfully disclosed by the Department. If you fail to furnish this information we will take no action to honor your request. Required information is indicated in CAPS.

FULL NAME OF REQUESTER: [PLEASE PRINT] \_\_\_\_\_

ADDRESS: [STREET] \_\_\_\_\_

[CITY] \_\_\_\_\_ [STATE] \_\_\_\_\_ [ZIP] \_\_\_\_\_

Phone: ( ) \_\_\_\_\_ Email: \_\_\_\_\_

SOCIAL SECURITY NUMBER: <sup>1</sup> \_\_\_\_\_ DATE OF BIRTH: [MM/DD/YY] \_\_\_\_\_

## Authorization to Disclose Personal Information to Another Person

I authorize the Department of Education and its agents to release to, and discuss with, the individual named below as my representative, any records of the Department regarding my student financial assistance loan or grant obligation(s) to the Department, for the purpose of assisting me in satisfying the obligation:

FULL NAME OF REPRESENTATIVE: \_\_\_\_\_

ADDRESS: [STREET] \_\_\_\_\_

[CITY] \_\_\_\_\_ [STATE] \_\_\_\_\_ [ZIP] \_\_\_\_\_

PHONE: ( ) \_\_\_\_\_ [Relationship To Requester] \_\_\_\_\_

I authorize the Department to honor this authorization unless and until I revoke it in a written notice and the designated office of the Department receives that notice. I understand that whenever requesting disclosure of information, the representative named here must submit information to verify his or her identity.

I UNDERSTAND THAT IN ORDER TO VERIFY HIS OR HER IDENTITY WHEN MAKING A REQUEST FOR DISCLOSURE BY TELEPHONE, THE REPRESENTATIVE MAY BE REQUIRED TO PROVIDE MY SSN, DOB, AND THE DATE ON WHICH I SIGNED THIS AUTHORIZATION.

I declare under penalty of perjury that I am the person named above as the requester, that I authorize release to the individual named as representative, and that the statements I provided here are true and accurate. I understand that any false statement is subject to punishment under 18 U.S.C. Section 1001 by fine or imprisonment of not more than five years, and that a knowing and willful request made under false pretenses for a record of an individual is subject to punishment under 5 U.S.C. Section 552a(i)(3) by a fine of up to \$5000.

DATE: \_\_\_\_\_ SIGNATURE \_\_\_\_\_

<sup>1</sup> You are not required to provide your SSN or DOB. However, we ask you to provide your SSN and DOB only to facilitate the identification of records relating to you, and unless you provide your SSN and DOB, we may be unable to locate any or all records pertaining to you.

Completed authorizations should be mailed to:

US DEPARTMENT OF EDUCATION  
PO BOX 5609  
GREENVILLE TX 75403-5609