HARVARD MEDICAL SCHOOL

PETITION TO RESTRICT DIRECTORY INFORMATION

Student’s Full Name:________________________________________________________
(please print)

HUID: ___________________________________________________________________

_____ I, the undersigned, request that Harvard Medical School install the following
restriction(s) on my Directory Information, preventing the release of any information about me,
except where permitted or required under FERPA.

Please check applicable restriction:

_____ Address Restriction
_____ Photo Restriction
_____ FERPA Block

_____ I, the undersigned request that no restriction be placed upon my directory information
by Harvard Medical School.

Student’s Signature:________________________________________________________

Date:____________________________________________________________________

This form must be submitted to the HMS Registrar’s Office in person, by mail, fax or scan:

Harvard Medical School
Office of the Registrar
25 Shattuck Street
Boston, MA 02115
Ph: (617) 432-1515 Fax: (617) 432-0275