



PARENT AUTHORIZATION FOR RELEASE OF FUNDS TO STUDENT

To: Office of Financial Assistance
Boston University
881 Commonwealth Ave., 5th Floor
Boston, MA 02215

Phone: 617-353-2965 **Fax:** 617-358-2792

From: _____ (Please print or type Parent's/Co-Signer's Name)

RE: Refunds

I authorize _____ (Student's full name),
_____ (BU I.D. #) to receive a refund from their student account for:

(Indicate each Semester/Year authorized)

Summer 20 Fall 20 Spring 20

Please release: Full amount available
 Indicate specific amount \$ _____.

(Parent's/Co-Signer's Signature)

(Date Signed)

*Please note that processing a credit release take 11-15 business days.
A check advance can be processed (1 per semester) within 48 hours.*

OFFICE USE ONLY

(CHECK ALL THAT APPLY): PAFALL PASPRG

DATE ENTERED: _____ FAA/PEER INITIALS: _____

ws/pub/par-release