

PERMISSION FOR RELEASE OF INFORMATION

Name:	Date:
Date of Birth:	Student ID or SSN:
Degree/Major Program	
Are you currently enrolled?	<input type="checkbox"/> Yes <input type="checkbox"/> No

STUDENT'S CURRENT PHONE NUMBER: _____

TYPE OF REQUEST: (Please check all that apply)

- Letter of Verification(Please specify semester) MM/YY _____
- Immunization Record
- Other (please specify) _____

NOTE: Educational verification may only be processed after first day of classes.

INFORMATION TO BE RELEASED TO:

NAME: _____

ADDRESS: _____

ATTN TO: _____

PHONE/FAX NUMBER: (If available) _____

Please choose Method:

<input type="checkbox"/> I want my request to be mailed to the above address <input type="checkbox"/> I prefer to pick up my request on given date. <input type="checkbox"/> I want my request to be fax	Student Signature: <input checked="" type="checkbox"/> _____
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Registrar – Office Use Only

Pickup Date: _____

Degree/Major: _____ Graduation date _____ Beginning Semester: _____

Semester verified: _____ Number of Credit for semester verified: _____

Processed by: _____ Date: _____