AUTHORIZATION/REQUEST FOR TRANSCRIPT REALEASE OF INFORMATION

Name ______________________ Maiden Name ______________________

Date of Birth ______________________ Graduation Year ______________________

Current Address ____

Telephone Number ______________________ Social Security # ______________________

I hereby authorize you to release, as custodian of my educational and/or medical records to any school college, university or other educational institution, hospital or other repository of medical records, social service agency, employer, retail business establishment including its officers, employees, or related personnel both individually and collectively. I understand in signing this authorization that the School District of University City or its authorized representative shall in no terms be liable for damages of whatever kind which may at any time result to me, my heirs, family, or associates because of compliance with this authorization and request for information or any other attempt to comply with it.
Permission for release of my educational record is here in granted to the person/school/agency listed below:

Name of recipient ______________________

____

Address 1 ______________________

Address 2 ______________________

City, State, Zip ______________________

Name of recipient ______________________

____

Address 1 ______________________

Address 2 ______________________

City, State, Zip ______________________

Name of recipient ______________________

____

Address 1 ______________________

Address 2 ______________________

City, State, Zip ______________________

Name of recipient ______________________

____

Address 1 ______________________

Address 2 ______________________

City, State, Zip ______________________

Signature ______________________ Witnessed ______________________

Revised 7/2004