



**AUTHORIZATION FOR RECORD RELEASE**

**Component of Record Requested**

This authorization is valid for 60 days.

Date of Request: \_\_\_\_\_

Transcript                       Medical Record                       Other (specify): \_\_\_\_\_

Current Name: \_\_\_\_\_

Name while attending (if different): \_\_\_\_\_

Current Address: \_\_\_\_\_

Phone #: \_\_\_\_\_ Social Security Number: \_\_\_\_\_

Dates of Attendance: \_\_\_\_\_ To: \_\_\_\_\_ PTK Member:     Yes     No

Did you Graduate? \_\_\_\_\_ Program: \_\_\_\_\_

Diploma                       Associate Degree                       Bachelor's Degree

Number of Transcripts Needed: \_\_\_\_\_ **\$5 Transcript Fee**

Number of Medical Record Copies Needed: \_\_\_\_\_ **\$5 Medical Record Fee**

**Signature Required:** \_\_\_\_\_

Send to:

Send to:

Send to:

Send to:

SONIS updated on: \_\_\_\_/\_\_\_\_/\_\_\_\_ by \_\_\_\_\_  
Amount Paid: \_\_\_\_\_ Date: \_\_\_\_\_ Ck # \_\_\_\_\_ Cash \_\_\_\_\_ CC \_\_\_\_\_