# AUTHORIZATION FOR RECORD RELEASE

## Component of Record Requested

This authorization is valid for 60 days.

_____ Transcript _____ Medical Record _____ Other (specify) _____

Current Name: _____

Name while attending (if different): _____

Current address: _____

_____

Phone No: _____ Social Security No: _____-____-_____

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 ____

401 Medical Park Drive Concord, NC 28025
704-403-1555 * 704-403-2077 FAX